2018

# Johannah Bright, Appellee, v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and St. Mark's Hospital, Appellants. Pia Merlo-Schmucker, Appellee, v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and St. Mark's Hospital, Appellants. Lisa Tapp, Appellee, v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and Ihc Health Services, Inc., Appellants : Brief of Appellee

Utah Supreme Court



Original Brief Submitted to the Utah Supreme Court; hosted by the Howard W. Hunter Law Library, J. Reuben Clark Law School, Brigham Young University, Provo, Utah.
Michael J. Miller, Kathleen J. Abke, Scarlet R. Smith, Strong & Hanni; attorneys for appellants.
Rhome D. Zabriskie, Zabriskie Law Firm LLC; Rand Nolen, David Hobbs, Fleming Nolen & Jez LLP; Troy L. Booher, Zimmerman Booher; attorneys for appellees.

No. 20180528-SC

IN THE
SUPREME COURT OF THE STATE OF UTAH

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Johannah Bright, *Appellee*,
v.
Sherman Sorensen, M.D., Sorensen Cardiovascular Group,
and St. Mark's Hospital, *Appellants*.

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Pia Merlo-Schmucker, *Appellee*,
v.
Sherman Sorensen, M.D., Sorensen Cardiovascular Group,
and St. Mark's Hospital, *Appellants*.

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Lisa Tapp, *Appellee*,
v.
Sherman Sorensen, M.D., Sorensen Cardiovascular Group,
and IHC Health Services, Inc., *Appellants*.

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# BRIEF OF APPELLEES

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On appeal from the Third Judicial District Court,
Salt Lake County, District Court Nos. 170906790 (Hon. Laura S. Scott),
170906130 (Hon. Patrick Corum), 170904956 (Hon. Barry Lawrence)

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Michael J. Miller
Kathleen J. Abke
Scarlet R. Smith
STRONG & HANNI
102 South 200 East, Suite 800
Salt Lake City, Utah 84111

*Attorneys for Appellants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

Troy L. Booher (9419)
Beth E. Kennedy (13771)
ZIMMERMAN BOOHER
341 South Main Street, Fourth Floor
Salt Lake City, Utah 84111
tbooher@zbappeals.com
bkennedy@zbappeals.com
(801) 924-0200

*Attorneys for Appellees Johannah Bright, Pia Merlo-Schmucker, and Lisa Tapp*


Additional Parties and Counsel on Following Page

**Additional Parties and Counsel**

Eric P. Schoonveld
Tawni J. Anderson
Nathan E. Dorsey
HALL PRANGLE & SCHOONVELD, LLC
111 East Broadway, Suite 700
Salt Lake City, Utah 84111

Andrew A. Warth
WALLER LANSDEN DORTCH & DAVIS, LLP
511 Union Street, Suite 2700
Nashville, Tennessee 37219

*Attorneys for St. Mark's Hospital*

Alan C. Bradshaw
Chad R. Derum
John T. Nelson
MANNING CURTIS BRADSHAW & BEDNAR PLLC
136 E. South Temple, Suite 1300
Salt Lake City, Utah 84111

*Attorneys for IHC Health Services, Inc.*

Rand Nolen, pro hac vice
David Hobbs, pro hac vice
FLEMING, NOLEN & JEZ, L.L.P.
2800 Post Oak Boulevard, Suite 4000
Houston, Texas 77056
Rand_Nolen@fleming-law.com
David_Hobbs@fleming-law.com
(713) 621-7944

Rhome D. Zabriskie (9113)
ZABRISKIE LAW FIRM LLC
899 North Freedom Boulevard
Suite 200
Provo, Utah 84604
rhomelawyer@yahoo.com
(801) 375-7680

*Attorneys for Appellees Johannah Bright, Pia Merlo-Schmucker, and Lisa Tapp*

## Current and Former Parties

This consolidated appeal involves:

- No. 20180528-SC, *Johannah Bright v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and St. Mark's Hospital*, D.C. No. 170906790
- No. 20180554-SC, *Pia Merlo-Schmucker v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and St. Mark's Hospital*, D.C. No. 170906130
- No. 20180690-SC, *Lisa Tapp v. Sherman Sorensen, M.D., Sorensen Cardiovascular Group, and IHC Health Services, Inc.*, D.C. No. 170904956

**Appellants/Defendants**

Sherman Sorensen, M.D. and Sorensen Cardiovascular Group, represented by:

Michael J. Miller
Kathleen J. Abke
Scarlet R. Smith
STRONG & HANNI

St. Mark's Hospital, represented by:

Eric P. Schoonveld
Tawni J. Anderson
Nathan E. Dorsey
HALL PRANGLE & SCHOONVELD, LLC

Andrew A. Warth
WALLER LANSDEN DORTCH & DAVIS, LLP

IHC Health Services, Inc., represented by:

Alan C. Bradshaw
Chad R. Derum
John T. Nelson
MANNING CURTIS BRADSHAW & BEDNAR PLLC

**Appellees/Plaintiffs**

Johannah Bright, Pia Merlo-Schmucker, and Lisa Tapp, represented by:

Troy L. Booher
Beth E. Kennedy
ZIMMERMAN BOOHER

Rand Nolen
David Hobbs
FLEMING, NOLEN & JEZ, L.L.P.

Rhome D. Zabriskie
ZABRISKIE LAW FIRM LLC

**Parties Below Not Parties to the Appeal**

None

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## Introduction

Over the course of a decade, Dr. Sherman Sorensen performed thousands of unnecessary heart procedures after falsely telling patients that they were at high risk of a stroke. He performed the procedures at two hospitals, St. Mark's and Intermountain. The hospitals knew about the unnecessary procedures because (i) Dr. Sorensen performed ten to twenty times more of these procedures than is typical, and (ii) other doctors at Intermountain and University of Utah Hospital pointed out that many of the procedures were unnecessary.

With actual knowledge of the misconduct, the hospitals decided not to notify patients that their heart procedures had been unnecessary. Instead, Dr. Sorensen and the hospitals created false documents and medical charts to conceal the misconduct, including documenting false medical conditions. They billed and accepted payment from insurance companies and patients. And they supplied Dr. Sorensen with the staff, facilities, and resources needed to perform these procedures at a highly suspect volume.

Intermountain eventually suspended Dr. Sorensen for his misconduct in light of complaints from other doctors, but still chose to conceal rather than to disclose the misconduct to patients. St. Mark's chose neither to suspend Dr. Sorensen nor to disclose the misconduct. Instead, St. Mark's permitted Dr. Sorensen to continue because its cardiac catheterization lab had become financially dependent upon the high volume of unnecessary procedures. As a

result, Dr. Sorensen's patients remained unaware of his misconduct—or the concealment—until they saw attorney advertising and spoke with an attorney.

The hospitals and Dr. Sorensen assert not only that they should escape liability for the unnecessary heart procedures because they successfully concealed their misconduct until the four-year statute of repose expired, but also that the patients are not entitled to any discovery to learn precisely all the ways in which the hospitals fraudulently concealed and facilitated the misconduct. In their view, the patients must know all of the details at the pleading stage to plead fraud with particularity. Fortunately, that is not the law in Utah.

The statute describes two circumstances in which a one-year statute of limitation applies, instead of the four-year statute of repose. Utah Code § 78B-3-404. The first circumstance is when the health care provider fraudulently conceals the misconduct. The second circumstance is when the health care provider wrongfully leaves a foreign object in the patient. Both are in play here.

As to the fraudulent concealment exception, the statute describes what allegations are necessary. The statute requires that the patients allege only that they were prevented from discovering the misconduct because of affirmative acts to fraudulently conceal it. Each patient here made the required allegation. And on the face of the complaint, the patients all filed within one year of discovering the fraudulent concealment, making a motion to dismiss directed at the timeliness of the claim procedurally unavailable. That should end the inquiry.

But the patients did more. They provided details of how Dr. Sorensen fraudulently concealed that the heart procedures were unnecessary, how Dr. Sorensen and the hospitals conspired to falsify records to conceal the misconduct (and get the insurance companies to pay for it), and how the hospitals decided to conceal rather than disclose the misconduct.

Based on these allegations, the patients' complaints are sufficient to advance past the pleading stage. This can be accomplished in two ways. First, this court can affirm the district courts' rulings that the pleadings are sufficient so discovery can proceed. Second, this court can reiterate the rule that motions to dismiss that target exceptions to limitation periods should be converted to motions for summary judgment to allow discovery targeted at the exception. In the summary judgment proceedings, the courts can consider evidence to decide whether the patients filed claims within a year of discovering the concealment.

As to the foreign object exception, this court in 1968 adopted the rule that a malpractice claim cannot expire until the patient discovers a foreign object in her body and knows that this gives rise to a "right of action." *Christiansen v. Rees*, 436 P.2d 435, 436 (Utah 1968). This court has recognized that the legislature codified that rule in 1972, and again in 1976 in the Healthcare Malpractice Act where it now resides. *Day v. Meek*, 1999 UT 28, ¶ 16 n.5, 976 P.2d 1202. The patients here discovered that the devices were wrongfully left in their hearts within a year of filing their lawsuits, so the foreign object one-year exception also is in play.

## Statement of the Issue

**Issue:** Whether the district courts correctly ruled that a complaint alleging medical malpractice filed after the repose period will survive a motion to dismiss if the complaint alleges the bases for the statutory fraudulent concealment exception and the statutory foreign object exception to the statute of repose.

**Standard of Review:** When reviewing a court's denial of a motion to dismiss, this court interprets the allegations in the complaint, and all reasonable inferences drawn therefrom, in the light most favorable to the plaintiff. *Russell Packard Dev., Inc. v. Carson*, 2005 UT 14, ¶ 34, 108 P.3d 741. The propriety of a motion to dismiss is a question of law that this court reviews for correctness. *Id.*

**Preservation:** This issue is preserved. [T.R.734-35; M.R.402-03; B.R.380-82.[1]]

[1] The patients use "T.R." to refer to the record in Lisa Tapp's case, "M.R." for Pia Merlo-Schmucker's case, and "B.R." for Johannah Bright's case.

## Statement of the Case

Over a thousand medical malpractice actions are pending against Dr. Sorensen and the hospitals where he performed heart procedures. [T.R.124; M.R.98; B.R.84.] The allegations in each lawsuit are substantially the same. [T.R.124; M.R.98; B.R.84.]

Dr. Sorensen engaged in misconduct by permanently installing medical devices in his patients' hearts even though the procedures were medically unnecessary. [T.R.126,132,138; M.R.102,107; B.R.88,94,97,99.] He and the hospitals then fraudulently concealed his misconduct by telling patients that the heart procedures were necessary. [T.R.124-27; M.R.98-101; B.R.84-87.]

After discovering the fraudulent concealment, the patients sued Dr. Sorensen and the hospitals. This appeal involves three of those cases:

- Lisa Tapp against Dr. Sorensen and IHC Health Services, Inc. [T.R.122];
- Pia Merlo-Schmucker against Dr. Sorensen and St. Mark's Hospital [M.R.96]; and
- Johannah Bright against Dr. Sorensen and St. Mark's Hospital [B.R.82].

Each of the defendants filed motions to dismiss based on the four-year statute of repose in the Utah Health Care Malpractice Act. [T.R.327,347; M.R.158,190; B.R.196,228.] Each court denied the motion because the patients had alleged the basis to apply the statutory fraudulent concealment exception instead of the statute of repose. [T.R.734-35; M.R.402-03; B.R.379-83.]

Because this appeal involves the denials of motions to dismiss, the operative facts are the allegations in the complaints. *Russell Packard Dev., Inc. v. Carson*, 2005 UT 14, ¶ 34, 108 P.3d 741.

For additional background on the relevant events, the court can consult *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 745 (10th Cir. 2018), in which the Tenth Circuit reversed the dismissal of fraud claims under the False Claims Act based upon many the same operative facts at issue here.[2] The *Polukoff* opinion is at Addendum I.

**1. Dr. Sorensen Fraudulently Misrepresents to the Patients that They Need to Undergo Heart Procedures**

These medical malpractice cases involve a particular type of heart procedure that closes a small opening in the heart called a "patent foramen ovale" (PFO) or an "atrial septal defect" (ASD). [T.R.124; M.R.98; B.R.84.] The procedure requires a device to be permanently implanted in the heart. [T.R.126,132,138; M.R.102,107; B.R.88,94,97,99.]

[2] In reversing a dismissal for the failure to plead fraud with particularity, the Tenth Circuit held that "'in determining whether a plaintiff has satisfied Rule 9(b), courts may consider whether any pleading deficiencies resulted from the plaintiff's inability to obtain information in the defendant's exclusive control.'" *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 745 (10th Cir. 2018) (quoting *George v. Urban Settlement Servs.*, 833 F.3d 1242, 1255 (10th Cir. 2016)). The court then recognized that this "reflects the principle that 'Rule 9(b) does not require omniscience; rather the Rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim.'" *Id.* (quoting *Williams v. Duke Energy Int'l, Inc.*, 681 F.3d 788, 803 (6th Cir. 2012)).

The well-accepted medical consensus is that a PFO or ASD normally does not require treatment. [T.R.125; M.R.99; B.R.85.] Indeed, about 25% of healthy adults have these small openings in their hearts and will never need treatment. [T.R.125; M.R.98; B.R.84.] A PFO closure is instead appropriate only in the rare circumstances in which the patient has had a particular type of stroke—recurrent cryptogenic strokes. [T.R.125; M.R.99; B.R.85.]

None of the patients here had recurrent cryptogenic strokes or any other medically accepted indications that would justify a PFO or ASD closure. [T.R.132-33; M.R.102-03; B.R.88-89.] Yet Dr. Sorensen concealed this fact from the patients by advising them to undergo the procedure, and he permanently installed the devices in each of their hearts, despite the lack of medical need. [T.R.126,132-38; M.R.101-02,107; B.R.88,94,97,99,202.]

To obtain their consent, Dr. Sorensen misrepresented to each patient that she had an "extreme risk of debilitating stroke," that the heart procedure was necessary to reduce that risk, and that the procedure was safe and recommended in the medical community. [T.R.128,134-36; M.R.100,103-04; B.R.86,90-91.]

Those statements were false. [T.R.128,134-36; M.R.100,103-04; B.R.86,90-91.] And over the course of a decade, Dr. Sorensen recommended—and performed—more than 4,000 of these heart procedures, creating a substantial profit for himself and the hospitals where he worked. [T.R.126-28; M.R.99-101; B.R.85-87.]

He performed the three heart procedures at issue here in 2008, 2009, and 2010. [T.R.136 (2008); M.R.101 (2010); B.R.88,202 (2009).]

**2. The Hospitals Decide to Conceal the Truth from the Patients**

Both of the hospitals, Intermountain and St. Mark's, knew that Dr. Sorensen was performing unnecessary heart procedures. Dr. Sorensen performed these procedures at a rate that dwarfed the rates in the rest of the country by a factor of ten-to-twenty fold. [M.R.99; B.R.85.] The sheer volume of Dr. Sorensen's heart procedures—heart procedures that should be performed rarely—provided the hospitals knowledge that he was performing them on patients who did not need them. [T.R.126-27; M.R.99; B.R.85.]

Confirming for the hospitals that Dr. Sorensen's heart procedures were unnecessary, Intermountain and St. Mark's received numerous complaints—including complaints from doctors at the University of Utah Hospital and internal complaints from Intermountain doctors—that Dr. Sorensen was "regularly performing unnecessary, invasive cardiac procedures on his patients." [T.R.127,129; M.R.99-100; B.R.85-86.]

In 2011, Intermountain finally had to take action. After conducting an internal audit, Intermountain stated that Dr. Sorensen had performed "multiple, medically unnecessary" heart procedures and that he was a "threat to the health and safety of the patients treated at IHC." [T.R.127.] Intermountain suspended Dr. Sorensen's cardiac privileges. [T.R.127.] Intermountain then moved to

suspend Dr. Sorensen from practicing medicine, and Dr. Sorensen soon resigned. [T.R.129-30.]

St. Mark's received notice that Intermountain had suspended Dr. Sorensen for performing unnecessary heart procedures. [M.R.100; B.R.86.] But unlike Intermountain, St. Mark's decided to allow Dr. Sorensen to continue to perform the unnecessary heart procedures at St. Mark's. [M.R.100; B.R.86-87.]

In fact, St. Mark's continued to advertise and promote Dr. Sorensen to the public and to profit from his work. [M.R.101; B.R.87.] St. Mark's continued to mislead the public about Dr. Sorensen because its cardiac catheterization laboratory had become financially dependent on the volume of Dr. Sorensen's heart procedures. [M.R.101; B.R.87.]

Despite knowing that most of the heart procedures Dr. Sorensen performed were medically unnecessary, both hospitals decided to conceal this information from the patients who had undergone the procedures and from the insurance companies who had paid for them. [T.R.137; M.R.105; B.R.87,92.]

In 2014, Intermountain sent a letter to all of the patients who had undergone the heart closure procedure, warning them about a problem with the device that had been permanently installed in them. [T.R.138.] Yet even then—after Intermountain had concluded its investigation, had actual knowledge that most of the heart procedures were medically unnecessary, and that Dr. Sorensen had resigned from the hospital in the face of threats to his medical license for this

very reason—Intermountain drafted the letter in a way that deliberately failed to inform these same patients that the heart procedures were medically unnecessary and that their consent was obtained fraudulently. [T.R.138.]

Instead, both hospitals created false medical records to make the heart procedures appear to be medically necessary. [T.R.128; M.R.100; B.R.86.] These false records not only concealed Dr. Sorensen's misconduct by misrepresenting material facts, but also induced the patients' insurance companies to pay for the unnecessary procedures, allowing Dr. Sorensen and the hospitals to profit. [T.R.5,16,128; M.R.5,15,100,105; B.R.5,16,86.] Had the insurance companies denied the claim after reviewing accurate medical records, the patients would have been alerted that something was wrong with their heart procedures.

**3. The Patients Finally Discover the Truth and File Lawsuits**

The patients eventually found out what Dr. Sorensen and the hospitals had done. They discovered the truth, not from the hospitals, but after they saw an attorney advertisement and talked with an attorney. [T.R.145; M.R.105; B.R.92.]

Each of them filed complaints shortly thereafter, in 2017—within one year of finding out about the fraudulent concealment and that the heart procedures were unnecessary. [T.R.1; M.R.1; B.R.1.] They alleged claims including negligence, negligent credentialing, and fraud. [T.R.138-42; M.R.106-10; B.R.93-97.] Their complaints are at Addenda D, E, and F.

The patients recognized that their filings were beyond the four-year statute of repose, so they alleged the basis to trigger the fraudulent concealment exception. The exception provides as follows:

> [I]n an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs.

Utah Code § 78B-3-404(2)(b).

In accordance with the statutory language, the patients alleged in their complaints that they were prevented from discovering the misconduct because Dr. Sorensen and the hospitals had affirmatively acted to fraudulently conceal the misconduct from them. [T.R.145-46; M.R.112; B.R.99-100.]

Specifically, the patients alleged that Dr. Sorensen and the hospitals "took affirmative steps to conceal [the] cause of action." [T.R.145; M.R.112; B.R.99.] They similarly alleged that Dr. Sorensen and the hospitals "created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures," including falsifying the patients' medical charts. [T.R.128; M.R.100; B.R.86.]

The patients alleged that these affirmative steps prevented them from discovering their claims. [T.R.145; M.R.112; B.R.99.] And each complaint stated

that the defendants' conduct "constitutes fraudulent concealment," and that the one-year period in the exception governs instead of the four-year repose period. [T.R.146; M.R.113; B.R.110.]

The patients also alleged that, despite having actual knowledge that most of the PFO and ASD closure procedures that Dr. Sorensen performed had been unnecessary, both Dr. Sorensen and the hospitals affirmatively decided to conceal that fact from the patients who had undergone the heart procedures and from all of the insurance companies who paid for the unnecessary heart procedures. [T.R.5,16,34,137; M.R.5,16,101,105; B.R.5,15,87,92.]

**4. Dr. Sorensen and the Hospitals Argue that the Patients Were Too Late**

The hospitals and Dr. Sorensen believed that they could avoid liability because they concealed their misconduct for more than four years. They filed motions to dismiss in each case, alleging that the patients' claims should be dismissed for a variety of reasons, three of which are relevant to this appeal.

**Fraudulent concealment exception -** First, Dr. Sorensen and the hospitals argued that the claims were time-barred under the four-year statute of repose. [T.R.332-33,358-60; M.R.168-70,206-08; B.R.207-09,245-47.] In so doing, they attempted to avoid the effect of the statutory fraudulent concealment exception.

Dr. Sorensen and the hospitals recognized that the patients had included the allegation required by statute and that they needed limited discovery to learn precisely what the hospitals had done, but they argued that something more was

required. Specifically, Dr. Sorensen and the hospitals argued that the exception could not apply because, under the "heightened pleading requirement" in rule 9(c), the patients had failed to make the allegation "with particularity." [T.R.336-40,371-73; M.R.177-79,203-05; B.R.215-17,242-45.]

Of course, because the patients have not yet been able to conduct even limited discovery, they have not yet discovered the particular details regarding how Dr. Sorensen and the hospitals concealed the misconduct from them. Only Dr. Sorensen and the hospitals have that information, and their success in concealing it for more than four years should not allow them to escape liability.

**Fraud –** Second, Dr. Sorensen and the hospitals argued that, under rule 9(c), the patients' independent fraud claims should be dismissed as well. [T.R.333-36,361-70; M.R.172-76,202-03; B.R.211-15,247-48.] Similar to their arguments about the statutory exception to the statute of repose, they argued that the fraud claims should be dismissed because the patients did not plead their independent fraud claims with particularity. [T.R.333-36,361-70; M.R.172-76,202-03; B.R.211-15,247-48.]

**Negligent credentialing –**Third, Dr. Sorensen (but not the hospitals) argued that the negligent credentialing claims should be dismissed because, in 2011—several years before the patients filed their claim, but after the unnecessary heart procedures—the Utah Legislature declared that negligent credentialing was no longer a cause of action. [T.R.328; M.R.201; B.R.240.]

### 5. The District Courts Deny the Motions and Allow Limited Discovery

The courts below were unanimous in their analysis of the fraudulent concealment exception and the sufficiency of the fraud claims. Only one court dismissed the negligent credentialing claim.

**Fraudulent concealment exception –** All three district courts denied the motions to dismiss the patients' claims as time-barred. [T.R.737; M.R.403; B.R.388.] The courts agreed that adjudicating the timeliness was inappropriate on a motion to dismiss because the complaints alleged the basis to put the fraudulent concealment exception in play. [T.R.735; M.R.402-03; B.R.380.] A motion to dismiss, of course, must rest solely on the contents of the complaint.

The courts agreed that the patients were entitled to discovery on the concealment. [T.R.735; M.R.403; B.R.380.] As one court put it, "[t]he issue of whether the plaintiff[s] can prove fraudulent concealment required under [the statutory exception] will have to be based upon what we learn factually in discovery and to be decided at summary judgment or at trial." [T.R.735.]

The courts agreed that rule 9(c) does not apply at the pleading stage to the patients' allegations related to the statutory exception to the statute of repose. [T.R.734-35; M.R.402-03; B.R.380.] As one court explained, "[i]t is important to note that there is a distinction here between the fraud associated with the 2008 surgery and any alleged fraud that took place thereafter that is relevant to [the] statute of limitation/repose." [T.R.736.] In other words, a cause of action alleging fraud falls under 9(c), but an exception to an affirmative defense does not.

**Fraud –** The courts also agreed that rule 9(c) did apply to the patients' affirmative causes of action concerning fraud, even though rule 9(c) did not apply to their allegations concerning the exception to the statute of repose. [T.R.736; M.R.403; B.R.386-87.] They ruled that the patients had failed to plead with particularity a fraud claim against either of the hospitals, and dismissed those claims on that basis. [T.R.736; M.R.403; B.R.386-87.] But they also agreed that the patients' fraud claims against Dr. Sorensen survived. [T.R.736; M.R.403; B.R.386-87.]

**Negligent credentialing –** Only one court ruled on Dr. Sorensen's argument that the negligent credentialing claim against the hospitals should be dismissed. That court dismissed Ms. Bright's negligent credentialing claim against St. Mark's by applying retroactively the 2011 statute eliminating the cause of action. [B.R.384.] This ruling is incorrect. On remand, Ms. Bright will challenge that ruling to revive that claim.

**The appeals** - Dr. Sorensen and the hospitals filed petitions under rule 5 of the Utah Rules of Appellate Procedure. This court granted the petitions and consolidated the appeals. The defendants filed three opening briefs, and the patients submit this single brief in response to all three opening briefs.

## Summary of the Argument

The district courts followed the proper procedure for adjudicating motions to dismiss. The defendants did not ask to convert the motions to motions for summary judgment, and the courts did not abuse their discretion in failing to do so sua sponte. On the face of the complaints, the patients' claims were not filed more than one year from the time they discovered the fraudulent concealment, so motions to dismiss for untimeliness were procedurally unavailable.

In addition, the statute of repose does not apply because the patients properly alleged the applicability of the one-year limitation periods in the statutory exceptions. The first exception allows a patient to file a claim within one year of discovering that the health care provider fraudulently concealed misconduct. Utah Code § 78B-3-404(2)(b). The second exception allows a patient to file within one year of discovering that a foreign object was wrongfully left in the patient. *Id.* § 78B-3-404(2)(a). Both exceptions are in play here.

**Fraudulent concealment exception -** The legislature codified the fraudulent concealment exception to the four-year statute of repose for good reason. The exception protects patients whose health care provider conceals misconduct and thereby prevents the patients from discovering their claims until the statute of repose expires. It recognizes that a health care provider should not escape liability from misconduct with more misconduct.

Here, the district courts correctly ruled that the complaints contain the allegations required by the statute to place the fraudulent concealment exception

in play. The complaints allege that Dr. Sorensen and the hospitals affirmatively acted to conceal their misconduct. They also allege that Dr. Sorensen and the hospitals "created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures," and then falsified the patients' medical charts. These allegations of affirmative acts satisfy the statute.

The complaints also allege that, despite having actual knowledge that most of Dr. Sorensen's heart procedures were unnecessary, both Dr. Sorensen and the hospitals affirmatively decided—and acted—to conceal this information from the patients, rather than to inform any of them. St. Mark's continued to advertise Dr. Sorensen's services after knowing that he was performing unnecessary heart procedures. Under Utah law, these decisions were additional affirmative acts that the fraudulent concealment exception.

Rule 9(c) of the Utah Rules of Civil Procedure does not change the fact that these allegations are all that the statute requires. The particularity requirement in rule 9(c) applies to claims and defenses, not to exceptions to affirmative defenses.

A plaintiff has no obligation to anticipate affirmative defenses when drafting a complaint. *E.g.*, *Brehany v. Nordstrom, Inc.*, 812 P.2d 49, 59 (Utah 1991). It would be difficult to impose a particularity requirement on allegations that anticipate affirmative defenses that have not yet been, and may never be, pled. Indeed, when a plaintiff files a complaint, she need not—and often cannot yet—provide all of the evidence to support that allegation.

But even if the court adopts the approach of a few jurisdictions that require a plaintiff to plead fraudulent concealment with particularity when it is an exception to an affirmative defense, the court should nonetheless affirm because the allegations here were sufficient under the standard adopted by a majority of jurisdictions.

Where, like here, the defendants have exclusive control over the information that would allow for the fraud to be described with particularity, this court requires that the motion to dismiss be converted to a motion for summary judgment to allow for targeted discovery on the fraud. To achieve the same result, this court could adopt the approach in many jurisdictions, which is to consider fraud to have been pled with sufficient particularity if any pleading deficiencies are the result of the defendant's having exclusive control over the information detailing the specifies about the fraud.

Under the rules, a patient should have an opportunity to obtain discovery before a court adjudicates the timeliness of the claim. This explains why motions to dismiss are procedurally unavailable to adjudicate statutory exceptions to the statute of repose, unless the face of the complaint shows that it was filed more than a year after the patient discovered the fraudulent concealment. Under Utah law, the courts here could have adjudicated such motions only if they were converted to motions for summary judgment. But the district courts here were

not asked to do so, and they did not abuse their discretion in declining to do so sua sponte.

**Foreign object exception -** This court also may affirm under the foreign object exception. The exception codifies this court's rule that a medical malpractice claim cannot expire until the patient learns that a foreign object was left in her body, and that leaving that object in the body gives rise to a "right of action." *Christiansen v. Rees*, 436 P.2d 435, 436 (Utah 1968). Here, the exception applies because the patients filed their claims within a year of discovering that Dr. Sorensen wrongfully left useless devices in their hearts.

**Negligent credentialing -** Finally, the district court adjudicating Ms. Merlo-Schmucker's claims did not err in refusing to dismiss her negligent credentialing claim against St. Mark's. Although the Utah Legislature eliminated the cause of action in 2011, this court has been clear that the elimination was not retroactive.

## Argument

### 1. The District Courts Correctly Denied the Motions to Dismiss

The district courts correctly declined to dismiss the complaints as time-barred under the four-year statute of repose. As discussed below, the complaints alleged that Dr. Sorensen and the hospitals affirmatively acted to conceal their misconduct, which is all the statute requires.

The statute first sets forth a two-year statute of limitation and a four-year statute of repose in subsection (1):

> A malpractice action against a health care provider shall be commenced within two years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered the injury, whichever first occurs, but not to exceed four years after the date of the alleged act, omission, neglect, or occurrence.

Utah Code § 78B-3-404(1).[3] The statute then describes two exceptions to subsection (1). These two exceptions do not toll the four-year repose period the defendants urge here, but instead impose their own one-year limitation periods. The patients will discuss these exceptions in reverse order.

**Fraudulent concealment -** One exception is the fraudulent concealment exception. That exception applies when a health care provider fraudulently conceals the misconduct from the patient:

> Notwithstanding Subsection (1) . . . in an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care

[3] Because the relevant portions of the statute have not been amended since the statute was enacted, the patients cite to the current version of the Utah Code. *Compare* 1976 Utah Laws 93-94, *with* Utah Code § 78B-3-404(2)(b).

> provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs.

*Id.* § 78B-3-404(2)(b).

The allegations here put the fraudulent concealment exception in play. Under the plain language of the exception, the patients had to allege only that "a health care provider" fraudulently concealed the misconduct. Dr. Sorensen did that when he lied to the patients that the heart procedure was medically necessary. Dr. Sorensen and the hospitals did that when they falsified medical records, intentionally concealed medical information from patients, and otherwise conspired to conceal the misconduct.

**Foreign object -** The other exception is the foreign objection exception. That exception applies when the health care provider wrongfully leaves a foreign object in the patient's body:

> Notwithstanding Subsection (1): in an action where the allegation against the health care provider is that a foreign object has been wrongfully left within a patient's body, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the existence of the foreign object wrongfully left in the patient's body, whichever first occurs

*Id.* § 78B-3-404(2)(a).

The foreign object exception also is in play because Dr. Sorensen wrongfully left a device (a foreign object) in each patient's heart, and the patients did not discover that the foreign objects were left in their bodies wrongfully until much later. This court should affirm.

### 1.1 The One-Year Limitation for Fraudulent Concealment Applies Instead of the Repose Period

The district courts correctly ruled that the patients' allegations were sufficient to place the fraudulent concealment exception in play. The exception protects patients whose health care providers conceal misconduct and thereby prevent patients from discovering the medical misconduct until the statute of repose expires. The fraudulent concealment exception recognizes that a health care provider should not escape liability for misconduct by committing more misconduct.

Protecting the patients comes at a cost, but not the cost the defendants articulate. It denies some health care providers the benefit of the certainty and predictability that statutes of repose are designed to guarantee. *Lee v. Gaufin*, 867 P.2d 572, 576 (Utah 1993). And it does so even though this predictability was one of the Utah Legislature's express purposes in enacting the Utah Health Care Malpractice Act. As the legislature explained, "[i]n enacting this act, it is the purpose of the Legislature to provide a reasonable time in which actions may be commenced against health care providers while limiting that time to a specific

period for which professional liability insurance premiums can be reasonably and accurately calculated." Utah Code § 78B-3-402(3).

But health care providers are denied that protection only when the misconduct was fraudulently concealed from the patient. *Id.* § 78B-3-404(2)(b). The fraudulent concealment exception reflects the legislature's balancing of competing policies: when a health care provider fraudulently conceals misconduct, the patient's right to pursue a remedy beyond the four-year period outweighs the policies underlying the statute of repose.

This explains why the legislature included the fraudulent concealment exception from the time it first enacted the statute of repose. *Compare* 1976 Utah Laws 93-94, *with* Utah Code § 78B-3-404(2)(b).

The legislature's balancing is consistent with Utah case law. Indeed, this court weighed the same policies—and reached the same conclusion—in the similar context of the statutory discovery rule. *Russell Packard Dev., Inc. v. Carson*, 2005 UT 14, ¶ 28, 108 P.3d 741. The court expressly "refuse[d]" to adopt a rule that would "reward a defendant's fraudulent and deceptive misbehavior by depriving an innocent plaintiff of a reasonable period within which to act." *Id.* As the court explained, "[t]o permit one practicing a fraud and then concealing it to plead the statute of limitations when, in fact, the injured party did not know of and could not with reasonable diligence have discovered the fraud would be not

only subversive of good morals, but also contrary to the plainest principles of justice." *Id.* (alteration and internal quotation marks omitted).

Indeed, the court has long recognized that it would "be imprudent to adopt a rule that might tempt some health care providers to fail to advise patients of mistakes that have been made and even to make efforts to suppress knowledge of such mistakes in the hope that the running of the statute of limitations would make a valid cause of action nonactionable." *Foil v. Ballinger*, 601 P.2d 144, 148 (Utah 1979).

Thus, like the Utah Legislature, this court has recognized that while statutes of repose serve an important purpose, that purpose is outweighed by ensuring that wrongdoers do not escape liability by fraudulently concealing their misconduct.

**Plain language -** Dr. Sorensen nonetheless asserts giving effect to the plain language would render "meaningless" the statute of repose. (Sorensen Op. Br. at 33-37.) He argues that, if there are exceptions to the repose period, doctors will face stale claims and "could never enjoy a repose." (Sorensen Op. Br. at 35-36.)

But doctors will face stale claims only if they fraudulently conceal their misconduct. An exception mitigating the harshness of a rule does not render the rule meaningless.

Next, Dr. Sorensen asserts that the fraudulent concealment exception is not an exception to the statute of repose. (Sorensen Op. Br. at 26-37.) He asserts that

the exception applies instead only to the two-year statute of limitation. His assertions make no sense because he gets it backward.

To begin, Dr. Sorensen's position contradicts the statutory language. The statute expressly states that the exception applies to the statute of repose. Specifically, the statute sets forth the statute of repose in subsection (1), then expressly states that "Notwithstanding Subsection (1)," a plaintiff who alleges that the health care provider fraudulently concealed misconduct may file an action within one year of discovering the fraud. Utah Code § 78B-3-404. The statute unambiguously applies the exception to the four-year statute of repose.

In fact, this court has held that the exception applies *only* to the repose period and not to the limitation period. In *Day v. Meek*, this court considered "whether subsection (a) is an exception to the four-year period *only* or an exception to *both* the two- and the four-year periods." 1999 UT 28, ¶ 11, 976 P.2d 1202. The court concluded that the fraudulent concealment exception applies only to the four-year repose period. *Id.* ¶ 22. The court reasoned that "it makes no sense" to apply the exception to the limitation period, as the exception would have the effect of shortening the limitation period. *Id.* ¶ 18.

Indeed, a patient ordinarily has two years to sue after discovering her claim. But under the fraudulent concealment exception, she instead would have only one year to file if she discovered fraud concealing the misconduct right away. *Id.* Thus, "the one-year limitation on cases involving fraudulent

concealment makes sense only if it comes into play after the expiration of the four-year repose period, which would otherwise cut off all causes of action." *Id.* ¶ 20.

The fraudulent concealment exception cannot apply to the two-year limitation period. Indeed, the two-year limitation period does not begin to run until the patient discovers her injury. Utah Code § 78B-3-404(1). At the same time the patient discovers the fraud, both the two-year and the one-year limitation periods would begin, so there is no two-year limitation period to except.

This court subsequently confirmed this analysis and conclusion. *Jensen v. IHC Hosps., Inc. (Jensen III)*, 2003 UT 51, ¶ 77, 82 P.3d 1076. In *Jensen III*, the court stated squarely that "the statutory fraudulent concealment exception applies only when a claim is brought after the statute of repose." *Id.* Dr. Sorensen does not acknowledge this precedent, let alone challenge it.

**Changed language –** Instead of dealing with this court's case law, Dr. Sorensen asserts that, because the statutory language has changed, this court's opinions no longer govern. (Sorensen Op. Br. at 27-28 n.2.) The prior version of the statute (interpreted in *Day* and *Jensen III*) stated that the limitation and repose periods were applicable "except that" the exceptions might apply. *Day*, 1999 UT 28, ¶ 5. In 2008, the Utah Legislature replaced "except that" with "Notwithstanding Subsection (1)." 2008 Utah Laws 403. Dr. Sorensen asserts that the replacement changed the meaning of the statute.

But Dr. Sorensen does not suggest how "notwithstanding" might mean something different from "except." Nor does Dr. Sorensen explain how the logic of this court's cases makes sense when the statute says "except" but not when the statute says "notwithstanding." In fact, the exception still makes sense only as an exception to the repose period. *Jensen III*, 2003 UT 51, ¶ 77; *Day*, 1999 UT 28, ¶ 10. Applying it to the limitation period (as Dr. Sorensen suggests) still "makes no sense" because it could only shorten the period rather than extend it. *Day*, 1999 UT 28, ¶ 18.

**Diligence -** Finally, Dr. Sorensen argues that the exception cannot apply because the patients were not diligent in attempting to discover his misconduct. (Sorensen Op. Br. at 58-64.) Of course, the patients did not discover that the heart procedures were unnecessary because Dr. Sorensen lied to them when he told them they were necessary. Dr. Sorensen does not explain how reasonable diligence requires one to assume or suspect that her doctor is lying.

Regardless, Dr. Sorensen cites opinions discussing the equitable discovery rule, under which a plaintiff is charged with knowledge of her cause of action if she "by reasonable diligence and inquiry should know" the relevant facts. *E.g.*, *Colosimo v. Roman Catholic Bishop*, 2007 UT 25, ¶ 17, 156 P.3d 806 (internal quotation marks omitted). He then concludes that the fraudulent concealment exception cannot protect the patients here because "nothing shows that they

made any inquiry into whether they had a cause of action." (Sorensen Op. Br. at 64.)

But the statute here requires only that the claim be "commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs." Utah Code § 78B-3-404(2)(b). The patients all filed within a year of seeing the advertisement about the unnecessary heart procedures, which thereby alerted the patients that Dr. Sorensen and the hospitals fraudulently concealed that fact from them.

And this court has been clear that a statutory discovery rule operates differently from the equitable discovery rule. *Russell Packard Dev., Inc. v. Carson*, 2005 UT 14, ¶¶ 25-26, 108 P.3d 741. To obtain the benefit of the equitable discovery rule, a plaintiff must have been diligent in discovering her claim. *Id.* ¶¶ 25-26. But the equitable discovery rule "applies *only* where a statute of limitations does not, by its own terms, already account for such circumstances—i.e., where a statute of limitations lacks a statutory discovery rule." *Id.* ¶ 25.

Where, like here, the statute contains an exception—indeed, an alternative one-year statute of limitation—what matters is when the plaintiff discovered or reasonably should have discovered the fraudulent concealment. *Id.* ¶ 26. That is why this court has held, for example, that a malpractice claim was timely even though it was filed eleven years after the misconduct. *Chapman ex rel. Chapman v.*

*Primary Children's Hosp.*, 784 P.2d 1181, 1185-87 (Utah 1989). The claim was timely because it was filed within a year of when the patients discovered that the health care providers had fraudulently concealed misconduct for a decade. *Id.* at 1184.

The rule makes sense. The statute protects patients who do not—and cannot—know that they have a cause of action because the doctor has fraudulently concealed his malpractice. Until they discover the fraudulent concealment, they have no reason to believe they have been harmed. It is difficult to understand how or why these patients would have "made any inquiry into whether they had a cause of action," as Dr. Sorensen asserts. (Sorensen Op. Br. at 64.) The patients here are the patients that the statutory exception is designed to protect. This court should reject Dr. Sorensen's attempt to escape liability for unnecessary heart procedures because his fraud was so effective.

### 1.2 The Patients' Allegations Were Sufficient to Require the Exception to Be Adjudicated Based on Evidence

The district courts also correctly ruled that the allegations in the patients' complaints were sufficient to survive the motions to dismiss. The statute requires a patient only to "allege[]" that the doctors fraudulently concealed their misconduct. Utah Code § 78B-3-404(2)(b). When she files a complaint, she need not—and often cannot yet —provide all of the evidence to support that allegation. Under the statute (and the opinions interpreting it), a patient has an

opportunity to obtain discovery before a court adjudicates the timeliness of the claim.

**Affirmative acts -** The statutory language is clear. The exception applies "in an action where it is *alleged* that a patient has been prevented from discovering misconduct on the part of a health care provider because the health care provider has affirmatively acted to fraudulently conceal the alleged misconduct." *Id.* (emphasis added). Here, the courts correctly ruled that each of the patients' complaints included the required allegations.

Dr. Sorensen and the hospitals assert that the complaints failed to allege an affirmative act. (Intermountain Op. Br. at 19-20; St. Mark's Op. Br. at 21, 29-30; Sorensen Op. Br. at 47-49, 52-53.) They assert that the complaints allege only a "failure to disclose" the misconduct, and that the choice to remain silent is never an affirmative act. They also assert that the complaints only allege fraud related to the initial procedure, not any subsequent fraud that concealed the causes of action. (Intermountain Op. Br. at 10, 14; Sorensen Op. Br. at 51-53.)

Their position overlooks the allegations in the complaint. Each complaint alleged that Dr. Sorensen and the hospitals "took affirmative steps to conceal [the] cause of action." [T.R.145; M.R.112; B.R.99.] The rule does not require allegations explaining how they took affirmative steps to conceal or what precisely those steps were, but the patients provided those allegations anyway.

Each complaint also alleged that Dr. Sorensen and the hospitals "created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures," and then falsified the patients' medical charts. [T.R.128; M.R.100; B.R.86.] And each complaint alleged that these affirmative steps prevented the patients from discovering their causes of action. [T.R.145; M.R.112; B.R.99.] Each complaint expressly stated that the defendants' conduct "constitutes fraudulent concealment" so the alternative one-year statute of limitation applies, not the four-year statute of repose. [T.R.146; M.R.113; B.R.100.]

**The Decision to Conceal –** The position of Dr. Sorensen and the hospitals also overlooks Utah law. While the allegations set forth above are sufficient, the complaints contain additional allegations that further satisfy the exception. Indeed, contrary to Intermountain and Dr. Sorensen's position, the patients' allegations concerning the defendants' "failure to disclose" the malpractice also are sufficient to satisfy the exception to the statute of repose.

Specifically, the patients alleged that despite having actual knowledge that most of the PFO and ASD closure procedures that Dr. Sorensen performed were unnecessary, both Dr. Sorensen and the hospitals decided to modify the medical charts and conceal from rather than inform any of the patients who had received them. [T.R.132,145; M.R.101,112; B.R.87,92,99.]

Under Utah law, this allegation asserts an affirmative act, and a further basis to apply the fraudulent concealment exception to the repose period. Indeed,

in the related context of the statutory discovery rule, this court has held that fraudulent concealment occurs when "one with a legal duty or obligation to communicate certain facts remain silent or otherwise acts to conceal material facts known to him. . . . The party's silence must amount to fraud, i.e., silence under the circumstances must *amount to an affirmation* that a state of things exists which does not exist." *Jensen v. IHC Hosps., Inc. (Jensen I)*, 944 P.2d 327, 333 (Utah 1997) (citing 37 Am. Jur. 2d Fraud & Deceit § 145 (1968) (emphasis added)). When one has actual knowledge in those circumstances, "silence is equivalent to a false representation." 37 Am. Jur. 2d Fraud & Deceit § 197 (2019).

This makes sense. While the failure to discover and expose misconduct does not constitute an affirmative act, the decision not to expose known misconduct can, and does here. Actual knowledge (not imputed knowledge) of the misconduct requires one to decide whether to disclose it, an affirmative act. Without actual knowledge of the misconduct, one only fails to discover the misconduct. This may not satisfy the exception, but is not what happened here.

Once health care providers discover misconduct, they not only have a duty to communicate that information to their patients, but also to make the conscious decision whether to disclose or instead conceal it. Indeed, "[c]ourts have long characterized the duty physicians [and other health care providers] have to their patients as fiduciary." *Sorensen v. Barbuto*, 2008 UT 8, ¶ 15, 177 P.3d 614. And doctors have a fiduciary duty to their patients to disclose "any material

information concerning the patient's physical condition." *Daniels v. Gamma W. Brachytherapy, LLC*, 2009 UT 66, ¶ 51, 221 P.3d 256 (internal quotation marks omitted). For this reason, the hospitals' actual knowledge is key.

Thus, in *Jensen I* this court recognized that, once a doctor has actual knowledge of malpractice, a doctor's duty to his patients renders his silence about the malpractice fraudulent concealment of the patient's cause of action. 944 P.2d at 333. The decision to conceal rather than disclose amounts to an affirmation—an affirmative act. *Id.*

This court should expressly adopt the same interpretation of the statutory fraudulent concealment exception and hold that a health care provider's decision to remain silent can be an affirmative act when the health care provider has actual knowledge of misconduct and decides to conceal it rather than to disclose it. The court need not do so in this case, however, because the hospitals also falsified medical records and affirmatively continued to advertise with actual knowledge that Dr. Sorensen was performing unnecessary heart procedures.

Just like fraudulent concealment in the context of the discovery rule, the statutory exception here requires affirmation—it applies if the "health care provider has *affirmatively acted* to fraudulently conceal" the malpractice. Utah Code § 78B-3-404(2)(b) (emphasis added). And to the extent the language is ambiguous as to whether an "affirmation" described in *Jensen I* means the doctor has "affirmatively acted" under the statute, the court should resolve the

ambiguity with the reading that avoids absurd consequences. *Bagley v. Bagley*, 2016 UT 48, ¶ 27, 387 P.3d 1000.

It would produce absurd consequences to construe a health care provider's decision to conceal (rather than to disclose) misconduct as a decision that involves no affirmative act. It would allow health care providers to avoid liability if—for four years—they decide to conceal misconduct when otherwise communicating with the patients. This would place health care providers who breach *two* duties to their patients in a better position than health care providers who breach only one duty. The legislature did not intend to shield a heath care provider who engages in additional misconduct, but to expose the health care provider who chooses not to conceal its misconduct.

This court rejected a similar absurd reading in *Day*. As the court explained, "health care providers accused of malpractice could conceivably assert their own fraudulent concealment as a bar to the suit, thus perversely converting their own misconduct into an affirmative defense. The legislature could not have intended such a result." *Day v. Meek*, 1999 UT 28, ¶ 19, 976 P.2d 1202.

The *Jensen I* reading likewise avoids this absurdity. The court should conclude that a health care provider "affirmatively acted to fraudulently conceal" the malpractice if, after it learned of misconduct, it decided to conceal the information from the patient.

Here, the patients alleged that Dr. Sorensen and the hospitals had actual knowledge that the heart procedures were unnecessary because of their highly suspicious volume and because other doctors alerted them to the unnecessary heart procedures. And yet after learning that most of the heart procedures were unnecessary, the hospitals chose to conceal that information instead of disclosing it both to the thousands of patients who underwent the heart procedures and to the insurance companies who paid for them. The court should hold that, if allegations of affirmative acts are required, then these allegations here are sufficient to trigger the exception.

### 1.3 The Motions to Dismiss Were Procedurally Unavailable

The statute requires only an allegation of fraudulent concealment, and not more. This makes sense. At the pleading stage, most patients have not discovered precisely how the hospitals and the doctors chose to conceal the misconduct from them. In this case, only Dr. Sorensen and the hospitals have the evidence to complete that picture.

Nor can district courts apply the exception until the parties have engaged in limited discovery on the fraud. Here, the district courts cannot adjudicate whether Dr. Sorensen and the hospitals did, in fact, fraudulently conceal the patients' causes of action without evidence. Indeed, these "are all highly fact-dependent legal questions" which makes it inappropriate to resolve them prior to discovery. *Berenda v. Langford*, 914 P.2d 45, 53 (Utah 1996).

This explains why the motions to dismiss were procedurally unavailable to raise defendants' arguments. Indeed, a plaintiff's complaint must contain the facts necessary for her causes of action, but it is well-settled that she has no obligation to anticipate affirmative defenses. *Brehany v. Nordstrom, Inc.*, 812 P.2d 49, 59 (Utah 1991). In particular, a plaintiff need not anticipate and refute a defendant's potential assertion of a statute of repose defense. *Nunnelly v. First Fed. Bldg. & Loan Ass'n*, 154 P.2d 620, 632-33 (Utah 1944).

Intermountain asserts that Utah courts "routinely apply Rule 9 when fraud is pled as a possible way around an affirmative defense." (Intermountain Op. Br. at 17.) But in support, Intermountain cites only one opinion, *Norton v. Blackham*, 669 P.2d 857 (Utah 1983). But *Norton* is a *summary judgment* case. The plaintiff in *Norton* alleged that, after a car accident, the defendant fraudulently induced her into entering into an agreement releasing him. *Id.* at 858. She made these allegations in response to the defendant's affirmative defense, not in the complaint. *Id.*

The *Norton* court affirmed summary judgment on the basis that the plaintiff's *evidence* of fraud was legally insufficient. *Id.* at 859. Yet the court also stated that "the issue was not properly pleaded" under rule 9—a statement that makes little sense given the procedural posture of the case (summary judgment) and the fact that the court weighed evidence (not allegations). *Id.* at 858. The court did not acknowledge the well-settled law that the plaintiff had no

obligation to anticipate the affirmative defense, let alone overturn it. The *Norton* opinion does not change Utah law.

And under Utah law, because a complaint need not include allegations related to an exception to a statute of repose defense, the defense is premature if asserted in a motion to dismiss (like Dr. Sorensen's and the hospitals' motions here). *Tucker v. State Farm Mut. Auto. Ins. Co.*, 2002 UT 54, ¶ 7, 53 P.3d 947.

There is an exception to the rule. A motion to dismiss may properly raise a statute of limitation or repose defense when "the complaint on its face shows the existence of [the] affirmative defense." *Id.* ¶ 8 (internal quotation marks omitted). A complaint shows the facts necessary to establish an affirmative defense when it contains all the dates necessary to understand when the cause of action arose, and to establish that the limitation or repose period has elapsed. *Id.*

This happens, for example, when a complaint alleging malpractice shows not only the date of a surgery, but also the date the patient found out that his surgeon removed the wrong part of his body. *E.g.*, *Roth v. Pedersen*, 2009 UT App 313, *2, 2009 WL 3490974 (Mem. Dec.). Under those circumstances, a defendant can assert a statute of limitation or repose defense in a motion to dismiss because no exception to the affirmative defense is in play. *Id.*

Dr. Sorensen and the hospitals argue that the exception to motions to dismiss being procedurally unavailable applies here. (Sorensen Op. Br. at 44-46;

Intermountain Op. Br. at 10; St. Mark's Op. Br. at 30-36.) They assert that the complaints, on their faces, establish that the claims are time-barred.

But the motions to dismiss were not procedurally available here. The face of each complaint does not show that the patient filed more than a year after discovering the fraudulent concealment. Ms. Tapp's complaint alleges that she discovered her legal injury in 2017, the year she filed her complaint. [T.R.145,147.] Ms. Tapp's complaint therefore shows only that she filed it within the one-year period provided by the fraudulent concealment exception. And Ms. Bright's and Ms. Merlo-Schmucker's complaints do not provide the date upon which they discovered their legal injuries. [M.R.96-114; B.R.82-101.]

None of the complaints contain the allegation necessary to establish an affirmative defense that the claims are untimely as a matter of law at the motion to dismiss stage. The motions to dismiss were procedurally unavailable, and the district courts correctly denied them.

The district courts agreed that the timeliness question was inappropriate for a motion to dismiss and should instead be adjudicated on summary judgment or, depending upon the evidence discovered, at trial. [T.R.735; M.R.403; B.R.380.] And they agreed that the patients are entitled to discovery on facts related to the exception. [T.R.735; M.R.403; B.R.380.] As one court put it, "[t]he issue of whether the plaintiff[s] can prove fraudulent concealment required under [the statutory exception] will have to be based upon what we

learn factually in discovery and to be decided at summary judgment or at trial." [T.R.735.]

The district courts were correct. Under Utah law, Dr. Sorensen and the hospitals could—and should—have raised the statute of repose defense in a summary judgment motion. *E.g.*, *Berenda v. Langford*, 914 P.2d 45, 47 (Utah 1996). But because they instead filed motions to dismiss, the courts could have adjudicated the motions only if they treated the motions as motions for summary judgment. *Tucker*, 2002 UT 54, ¶ 11. And the courts were not required to convert the motions.

This court has been clear about the rule: "where a plaintiff's complaint describes events which establish when a statute of limitations begins to run but fails to explicitly set forth the relevant date on which those events occurred, a defendant may raise a statute of limitations defense in a motion to dismiss under rule 12(b)(6) of the Utah Rules of Civil Procedure, *provided that the trial court treats the motion as one for summary judgment*, thus giving all parties the 'reasonable opportunity to present all material made pertinent to such a motion." *Id.* (quoting Utah R. Civ. P. 12(b)) (emphasis added).

The rule allows the non-moving party to respond to the motion by requesting limited discovery to obtain evidence to oppose the defense. Utah R. Civ. P. 56(d)(2). This allows the statutory exception to the statute of repose to be

adjudicated at the beginning of the lawsuit, but only after all of the evidence is brought to light.

This practice is consistent with this court's case law. For example, in *Tucker*, the defendant asserted a statute of limitation defense in a motion to dismiss. 2002 UT 54, ¶ 10. The district court exercised its discretion to treat the motion as one for summary judgment. *Id.* And in doing so, "the trial court became able to ascertain the relevant date for statute of limitations purposes." *Id.*

The trial court followed the same procedure in *Colosimo*. The defendants asserted a statute of limitation defense in motions to dismiss. *Colosimo v. Roman Catholic Bishop*, 2007 UT 25, ¶ 7, 156 P.3d 806. The district court adjudicated the timeliness issue, but only after treating the motions to dismiss as summary judgment motions and considering evidence in the form of affidavits. *Id.* ¶ 8.

But here, neither Dr. Sorensen nor the hospitals asked the courts to treat their motions as motions for summary judgment. Nor do they argue on appeal that the courts abused their discretion in declining to do so sua sponte. The district courts were correct in declining to adjudicate the exception to the affirmative defense at the pleadings stage.

### 1.4 The Allegations Are Sufficient Because Rule 9(c) Does Not Apply

The district courts also correctly ruled that the patients did not need to plead with particularity their allegations related to the exception. [T.R.734-35; M.R.402-03; B.R.380.]

Rule 9 states that, "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." Utah R. Civ. P. 9(c). Dr. Sorensen and the hospitals assert that the patients' complaints "alleg[ed] fraud" related to the fraudulent concealment exception to the statute of repose.

But the particularity requirement applies to affirmative causes of action and affirmative defenses, not to allegations related to an exception to a statute of repose. This makes sense because a plaintiff has no obligation to anticipate any affirmative defenses when drafting a complaint. *E.g.*, *Brehany*, 812 P.2d at 59. It would be difficult to impose a particularity requirement on allegations that anticipate affirmative defenses that have not yet been, and may never be, pled.

And rule 9 goes on to clarify that allegations related to a statute of limitation defense "may be alleged generally"—i.e., not with particularity:

> In pleading the statute of limitations it is not necessary to state the facts showing the defense but it may be alleged generally that the cause of action is barred by the statute.

*Id.* R. 9(i). It is difficult to understand why the burden would be greater in a complaint responding to this defense before it is raised.

The position of Dr. Sorensen and the hospitals conflates the requirements for the patients' causes of action (which must be pled with particularity) with the requirements for their allegations related to the exception to the statute of repose. The particularity requirement in rule 9(c) applies only to the allegations required

in rule 8, and rule 8 does not require allegations related to exceptions to affirmative defenses.

Specifically, rule 8 describes what must be alleged in pleadings—claims, defenses to claims, and affirmative defenses. Utah R. Civ. P. 8(a)-(c). Rule 9 then specifies how those allegations must be made if they are related to fraud claims or defenses. Rule 9 provides that, "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." *Id.* R. 9(c). The rule "supplements but does not supplant Rule 8['s] notice pleading" standard. *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 186 (5th Cir. 2009). In other words, rule 9 clarifies how fraud must be alleged when an allegation of fraud is required under rule 8. It does not add to the list of what must be alleged.

Instead, the *statute* governs what must be alleged. It provides that a patient must allege that she "has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct." Utah Code § 78B-3-404(2)(b). The statute does not require the fraudulent concealment to be pled with particularity. Nor does it require the patient to describe how the health care provider fraudulently concealed the misconduct. It requires only an allegation that the health care provider fraudulently concealed the misconduct.

The minimal requirement makes sense at the pleading stage, when the patient has not yet discovered the full details of the fraud. Once the patient

alleges that the health care provider fraudulently concealed the misconduct, the one-year fraudulent concealment exception is in play. The patient, after discovery, must later prove that she commenced the claim within one year after the patient "discover[ed], or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occur[ed]." *Id.*

This court's case law draws the same distinction between claims and exceptions to statutes of repose. *Jensen III*, 2003 UT 51, ¶ 35 n.10. As this court put it, "[t]he term 'independent fraud claim' refers to plaintiffs' cause of action for fraudulent concealment. This cause of action is separate from plaintiffs' allegations of fraudulent concealment for purposes of tolling the statute of limitations." *Id.*

This explains why the district courts here ruled that the patients' allegations of fraudulent concealment for purposes of the exception were sufficient, yet dismissed their causes of action for fraud against the hospitals as insufficiently pled under rule 9(c). [T.R.734-36; M.R.402-03; B.R.380,386-87.] As one of the courts correctly explained, "[i]t is important to note that there is a distinction here between the fraud associated with the 2008 surgery and any alleged fraud that took place thereafter that is relevant to [the] statute of limitation/repose." [T.R.736.]

Dr. Sorensen and the hospitals, however, argue that that Utah courts have dismissed complaints that fail to allege with particularity fraudulent

concealment that is an anticipatory response to a statute of repose defense. (Intermountain Op. Br. at 16-19; Sorensen Op. Br. at 53-58; St. Mark's Op. Br. at 18-26.) The opposite is true. No opinion from this court has ever held that the 9(c) requirement applies to allegations concerning the statutory exceptions.

Most of the opinions cited by Dr. Sorensen and the hospitals explain that the 9(c) requirement applies to all fraud-based causes of action, including "misrepresentations, omissions, or other deceptions covered by the term 'fraud' in its broadest dimension"—an issue that is not raised or disputed here. *Williams v. State Farm Ins. Co.*, 656 P.2d 966, 971 (Utah 1982); (Intermountain Op. Br. at 16).[4]

Dr. Sorensen also cites *Christensen v. Board of Review of Industrial Commission* as explaining the pleading requirements for a fraud claim. (Sorensen Op. Br. at 54 (citing 579 P.2d 335, 338 (Utah 1987)).) But the quote comes from a dissenting opinion in the case, which affirms findings made by a board of review of an industrial commission. 579 P.2d at 335, 338. It is neither a holding of this court nor relevant to any of the issues presented here.

[4] S*ee also* *Precision Vascular Sys., Inc. v. Sarcos, L.C.*, 199 F. Supp. 2d 1181, 1191-92 (D. Utah 2002) (Sorensen Op. Br. at 53); *State v. Apotex Corp.*, 2012 UT 36, ¶ 22, 282 P.3d 66 (Intermountain Op. Br. at 16 n.19); *Armed Forces Ins. Exch. V. Harrison*, 2003 UT 14, ¶¶ 16-18, 50 P.3d 35 (Sorensen Op. Br. at 54); *Robinson v. Robinson*, 2016 UT App 33, ¶¶ 49-50, 368 P.3d 105 (St. Mark's Op. Br. at 20); *Fid. Nat'l Title Ins. Co. v. Worthington*, 2015 UT App 19, ¶ 18, 344 P.3d 156 (Sorensen Op. Br. at 55; St. Mark's Op. Br. at 19); *Shah v. Intermountain Healthcare, Inc.*, 2013 UT App 261, ¶¶ 10-12, 314 P.3d 1079 (St. Mark's Op. Br. at 20, 25-26).

A few of the other opinions that Intermountain cites explain that the 9(c) requirement applies to the defenses asserted in a defendant's answer—another issue not raised or disputed here. *GDE Constr., Inc. v. Leavitt*, 2012 UT App 298, ¶¶ 13-14, 294 P.3d 567 (Intermountain Op. Br. at 16 n.19); *Otsuka Elecs. (USA, Inc.) v. Imaging Specialists, Inc.*, 937 P.2d 1274, 1278 (Utah Ct. App. 1997) (Intermountain Op. Br. at 16 n. 19).

Similarly, although Intermountain asserts that the Federal Practice & Procedure treatise "makes clear allegations of fraudulent concealment meant to toll a limitations period 'fall within the heightened pleading requirement of Rule 9(b),'" the quoted section of the current version of the treatise in fact addresses only the requirements of a defendant's answer. (Intermountain Op. Br. at 18-19.)

Intermountain does not quote the current version, so it is unclear whether a prior version conflated the rule as Intermountain suggests. (*Id.*) But the current version is clear and addresses only the requirements for a defendant's answer. It explains that, "inasmuch as the defense of fraud cannot be raised in an answer under a general denial because Federal Rule of Civil Procedure 8(c) requires that defense to be pleaded affirmatively, the assertion of such a defense is an allegation of fraud and is subject to the heightened pleading requirements of Rule 9(b)." 5A Fed. Prac. & Proc. Civ. §1297 (4th ed. 2019). It therefore does not apply here.

The remaining opinions from Utah courts cited by Dr. Sorensen and the hospitals are more directly on point but do not change the result. (Intermountain Op. Br. at 17; Sorensen Op. Br. at 54; St. Mark's Op. Br. at 24.) For example, in *Chapman ex rel. Chapman v. Primary Children's Hospital*, this court held that the plaintiff's allegations of fraudulent concealment were sufficient to establish the applicability of the fraudulent concealment exception even though the same allegations were insufficient to support the independent causes of action for fraudulent concealment against some of the defendants. 784 P.2d 1181, 1184-86 (Utah 1989). Notably, the appeal was before the court on summary judgment, not after the denial of a motion to dismiss. *Id.* at 1185.

In *Chapman*, the plaintiffs alleged a cause of action for fraudulent concealment against several health care defendants. *Id.* at 1185-86. Although the plaintiffs filed the complaint more than a decade after the malpractice, the plaintiffs did not include in the complaint separate allegations related to the statutory exception. *Id.* at 1184.

Nonetheless, this court held that the statutory exception was properly invoked—and satisfied—by the allegations supporting the independent cause of action. *Id.* at 1184-85. As the court explained, the "plaintiffs' allegations of fraudulent concealment bring their causes of action under section 78-14-4(1)(b)," the prior codification of the statutory exception. *Id.* at 1184. The court construed

the allegations in the light most favorable to the plaintiffs and concluded that the exception applied and the lawsuit "was therefore timely." *Id.* at 1184-85.

In determining whether the exception applied, the court did not analyze the 9(c) pleading requirements. *Id.* Nor did it suggest that they would apply to the exception. *Id.* Intermountain is therefore mistaken when it asserts that in *Chapman*, "[t]his Court applied Rule 9 to the statute at issue here." (Intermountain Op. Br. at 17 (emphasis omitted).)

The *Chapman* court instead analyzed and applied the 9(c) pleading requirements only with respect to the affirmative claims for fraud. *Chapman*, 784 P.2d at 1185-87. In so doing, the court held that, under rule 9(c), the allegations against the doctor and the hospital were sufficient, but the allegations against the remaining defendants were not. *Id.* at 1187.

Of course, those were the same allegations that the court deemed sufficient to render the complaint timely. *Id.* at 1184-85. The *Chapman* opinion therefore confirms that rule 9(c) applies to independent causes of action but not to the fraudulent concealment exception.

The second opinion is *Roth v. Pedersen*, an unpublished memorandum decision from the court of appeals. 2009 UT App 313, 2009 WL 3490974 (Mem. Dec.). (Intermountain Op. Br. at 18; Sorensen Op. Br. at 53; St. Mark's Op. Br. at 22.) Unlike this court's opinion in *Chapman*, the panel in *Roth* did suggest that rule 9(c) applies to the statutory exception. *Roth*, 2009 UT App 313, at *3. But the

panel did so only in dicta—the particularity requirement did not form the basis for the decision. *Id.*

Instead, the panel held that the plaintiff's malpractice action against a doctor was time-barred because he filed it more than four years after he became aware of the malpractice. *Id.* at *2. There was no question that the plaintiff immediately understood he had been harmed. *Id.* Indeed, the surgeon removed the wrong part of the plaintiff's body and he had to undergo "corrective surgery" to remove the correct part. *Id.* The question was only whether the plaintiff's cause of action against the doctor simultaneously accrued. *Id.*

The panel held that the cause of action accrued for both defendants at the same time, and thus the complaint was time-barred. *Id.* "It is clear from the pleadings that [the plaintiff] was aware that a legal injury had occurred at least by the time he initiated legal action against the general surgeon in May 2006. Thus, [he] knew both that he had suffered a legal injury and that it had happened during the resection surgery. That awareness triggered the statute of limitations regardless of whether [he] knew the precise identity of the wrongdoer. . . . Accordingly, we conclude that the grant of the motion for judgment and subsequent dismissal were appropriate because [the plaintiff] failed, as required by the Act, to commence litigation within two years of discovery of his legal injury, which occurred, at the very latest, in May 2006." *Id.*

The panel discussed the applicability of rule 9(c) to the fraudulent concealment exception only after reaching this conclusion. *Id*. at *3. The discussion in the memorandum decision is therefore dicta. And it is inconsistent with the opinions from this court. It has no precedential value.

Under Utah law, rule 9(c) does not apply to exceptions to affirmative defenses. Those should be adjudicated on summary judgment, where all the facts can come to light through discovery.

### 1.5 The Allegations Are Sufficient Even if Rule 9(c) Applies

Even if the court adopts the approach of a few jurisdictions that require a plaintiff to plead fraudulent concealment with particularity when it is an exception to an affirmative defense,[5] the court should nonetheless affirm because the allegations here were sufficient under the standard adopted by a majority of jurisdictions.

Where, like here, the defendants have exclusive control over the information that would allow for the fraud to be described with particularity, this court requires that the motion to dismiss be converted to a motion for summary judgment to allow for targeted discovery on the fraud. *Tucker v. State*

[5] *Summerhill v. Terminix, Inc.*, 637 F.3d 877, 880 (8th Cir. 2011) (Intermountain Op. Br. at 19 n.22); *Gulley v. Pierce & Assocs., P.C.*, 436 F. App'x 662, 664 (7th Cir. 2011) (Intermountain Op. Br. at 19 n.22); *Ballen v. Prudential Bache Sec., Inc.*, 23 F.3d 335, 337 (10th Cir. 1994) (Intermountain Op. Br. at 19 n.22); *Armstrong v. McAlpin*, 699 F.2d 79, 88 (2d Cir. 1983) (Intermountain Op. Br. at 19 n.22);*Conerly v. Westinghouse Elec. Corp.*, 623 F.2d 117, 120 (9th Cir. 1980) (applying California law) (Intermountain Op. Br. at 19 n.22); *Chafin v. Wisconsin Province of Soc'y of Jesus*, 917 N.W.2d 821, 825 (Neb. 2018) (Sorensen Op. Br. at 54).

*Farm Mut. Auto. Ins. Co.*, 2002 UT 54, ¶ 7, 53 P.3d 947. To achieve the same result, this court could adopt the approach in many jurisdictions, which is to consider fraud to have been pled with sufficient particularity if any pleading deficiencies are the result of the defendant's having exclusive control over the information detailing the specifies about the fraud.

As the Tenth Circuit recently held in reviewing allegations outlining the fraud of Dr. Sorensen and the hospitals in a False Claims Act case, "'in determining whether a plaintiff has satisfied Rule 9(b), courts may consider whether any pleading deficiencies resulted from the plaintiff's inability to obtain information in the defendant's exclusive control.'" *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 745 (10th Cir. 2018) (quoting *George v. Urban Settlement Servs.*, 833 F.3d 1242, 1255 (10th Cir. 2016)). The court then recognized that this "reflects the principle that 'Rule 9(b) does not require omniscience; rather the Rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim.'" *Id.* (quoting *Williams v. Duke Energy Int'l, Inc.*, 681 F.3d 788, 803 (6th Cir. 2012)). The Tenth Circuit is not an outlier. [6]

[6] *United States ex rel. Vatan v. QTC Med. Servs., Inc.*, 721 F. App'x 662, 663–64 (9th Cir. 2018); *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 512 (6th Cir. 2007); *Hill v. Morehouse Med. Assocs., Inc.*, No. 02-14429, 2003 WL 22019936, at *3 (11th Cir. Aug. 15, 2003); *United States ex rel. Russell v. Epic Healthcare Mgmt. Grp.*, 193 F.3d 304, 308 (5th Cir. 1999), *abrogated on other grounds by United States ex rel. Eisenstein v. City of New York*, 556 U.S. 928, 937 (2009); *Emery v. Am. Gen. Fin., Inc.*, 134 F.3d 1321, 1323 (7th Cir. 1998); *In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1417–18 (3d Cir. 1997); *Wexner v. First*

While this court may not want to adopt this approach for all types of fraud claims, it should adopt this approach when the fraud is an exception to an affirmative defense. For fraud claims more generally, the plaintiff often will obtain discovery on a non-fraud (often negligence or breach of contract) claim, and when the details of the fraud are discovered, the plaintiff can amend the complaint to include the fraud claim and allege it with particularity. But when the fraud is an exception to a statute of repose, the plaintiff will never uncover the fraud because the case will be dismissed at the pleading stage. The relaxed pleading standard therefore makes sense when the fraud is a defense to a statute of repose and the facts detailing the fraud, like the facts here, are within the exclusive control of the defendants.

In this case, the patients' allegations are sufficient to satisfy the relaxed rule 9(c) standard because the details of the fraud are within the exclusive control of the defendants and the defendants understand the nature of the patients' claims. With the relevant hospital files and notes, as well as the depositions of employees, the particularities of the fraud will become clear. Therefore, even if this court concludes that the patients had to satisfy rule 9(c) in alleging an exception to the statute of repose, the court should hold that patients did so because the relaxed standards applies.

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*Manhattan Co.*, 902 F.2d 169, 172 (2d Cir. 1990); *New England Data Servs., Inc. v. Becher*, 829 F.2d 286, 290 (1st Cir. 1987); *In re O.P.M. Leasing Servs., Inc.*, 32 B.R. 199, 203 (Bankr. S.D.N.Y. 1983).

### 2. The Foreign Object Exception to the Statute of Repose Is Also in Play Under the Allegations in These Cases

This court also may affirm the district courts' denials of the motions to dismiss on the other statutory exception, the foreign object exception. The exception applies because the patients filed their complaints within a year of discovering that Dr. Sorensen had implanted the devices in their hearts wrongfully.

The foreign object exception applies if a foreign object was wrongfully left in a patient's body. It provides as follows:

> in an action where the allegation against the health care provider is that a foreign object has been wrongfully left within a patient's body, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the existence of the foreign object wrongfully left in the patient's body, whichever first occurs.

Utah Code § 78B-3-404(2)(a).

The exception is a codification of a rule crafted by this court prior to the enactment of the Health Care Malpractice Act. The rule requires both knowledge of the foreign object in the body and knowledge of the right of action stemming from the leaving of the foreign object in the body.

In 1968, in *Christiansen v. Rees*, this court overturned precedent to the contrary, adopted the view that a plaintiff must know "of his injury and right of action," and held that "where a foreign object is negligently left in the body of a patient during an operation and the patient is ignorant of the fact, and

consequently of his right of action for malpractice, the cause of action does not accrue until the patient learned of the presence of such foreign object in his body." 436 P.2d 435, 436 (Utah 1968).

In 1971, the Utah Legislature codified the discovery rule articulated in *Rees*. 1971 Utah Laws 614 ("after the plaintiff discovers, or through the use of reasonable diligence, should have discovered the injury"). And this court recognized that the prior rule was then "codified" in the 1976 Utah Health Care Malpractice Act. *Day v. Meek*, 1999 UT 28, ¶ 16 n.5, 976 P.2d 1202.

The foreign objection exception therefore codifies the rule set forth in *Rees*, which requires knowledge of both the presence of the foreign object and of a *legal* injury. The unnecessary heart procedures here left an unnecessary medical device in each patient's body without informed consent. Dr. Sorensen fraudulently concealed that the procedures were unnecessary when he falsely told the patients that heart procedures were necessary. And the patients brought their claims within a year of discovering that the foreign objects had been placed and left in their bodies wrongfully.

This court can affirm on the alternative ground based upon the foreign object exception. The patients raised this argument below, even though it did not form the basis of the district courts' rulings. (T.R.539-40; B.R.689-95; M.R.660-61); *Bailey v. Bayles*, 2002 UT 58, ¶ 10, 52 P.3d 1158 (appellate courts may affirm "on any legal ground or theory apparent on the record") (citation omitted).

Dr. Sorensen and the hospitals may argue that the devices were not foreign objects because they were intentionally placed in the bodies. [T.R. 750.] This argument fails because the plain meaning of "foreign object" in this context is an object that does not exist naturally in the body.

The reasoning of other courts confirms that the devices here were foreign objects. For example, the Tennessee Supreme Court rejected the argument that an object that was intentionally placed in a patient's body could not satisfy Tennessee's foreign objection exception. *Chambers v. Semmer*, 197 S.W.3d 730, 733 (Tenn. 2006). Like the defendant here, the defendants in *Chambers* argued "that a surgical hemoclip intentionally placed in a patient's body with the intent that it permanently remain cannot be a 'foreign object' that establishes an exception to the one-year statute of limitations or the three-year statute of repose . . . even if the surgery is performed negligently." *Id.*

Even though the Tennessee statute required that the foreign object be *negligently* left in the patient's body—while Utah's exception more broadly extends to objects *wrongfully* left—the court rejected the defendants' argument. The court first cited prior cases holding that the foreign object exception "was intended to apply to cases where the defending health care provider was in some way responsible for the initial presence of the foreign object complained of." *Id.* at 734. The court then held that "all that is required under [the foreign object exception] is that an object be 'negligently left in a patient's body'" and that to

determine whether that has happened, "a court must look beyond whether a surgical object or device is *designed* to be used intentionally and to remain permanently and must fully consider the circumstances of each case." *Id.* at 736.

The Georgia Court of Appeals reached a similar result. *Norred v. Teaver*, 740 S.E.2d 251, 254 (Ga. Ct. App. 2013). The *Norred* court held that "the limitation period begins to run upon the discovery of an object not originating in the person's body that is caused or allowed to remain in the body. It is immaterial under the plain meaning of this language whether the object is caused to remain intentionally or unintentionally." *Id.*

For the same reason, an Ohio court held that an IUD could be a foreign object that can trigger the exception even though it was intentionally placed—depending on whether the placement was wrongful. *Beatman v. Gates*, 521 N.E.2d 521, 523 (Ohio Ct. App. 1987). The court recognized that whether an IUD was a foreign objection hinged upon "whether appellee indicated to appellant while he was examining and treating her that the IUD had repositioned itself within her body, or whether he failed to notify her of such occurrence thereafter; and when appellant knew or should have known that the IUD had migrated from its original location within her body." *Id.*

These jurisdictions, and many others, struggle with distinguishing between foreign objects negligently left in the body and foreign objects intentionally left in the body because their statutes use the word "negligently."

*E.g.*, *Hershley v. Brown*, 655 S.W.2d 671, 675 (Mo. Ct. App. 1983) (interpreting exception that requires "the act of neglect complained of is introducing and negligently permitting any foreign object to remain within the body"). But Utah's statute avoids this issue because it uses the broader term "wrongfully," which encompasses both negligent and intentional wrongdoing.

Because the devices here were wrongfully left in the patients' bodies, the only issue is whether the patients commenced their actions within one year of discovering "the existence of the foreign object wrongfully left in the patient's body." Utah Code § 78B-3-404(2)(a). As discussed above, this statute codifies the rule from *Rees* and requires knowledge of both the foreign object and the right of action. *Day*, 1999 UT 28, ¶ 16 n.5. The patients here satisfied that standard because they filed their claims within a year of learning that the devices were wrongfully left in their bodies.

Dr. Sorensen and the hospitals may argue that *Day* was wrongfully decided and that the foreign object exception does not codify the rule from *Rees*. Specifically, they may argue that the foreign object exception requires only discovery of the object, not that the object was wrongfully left in the body. If the defendants assert that the statute is ambiguous on this point, the court should reject the defendants' interpretation because it leads to an absurd consequence. *Bagley v. Bagley*, 2016 UT 48, ¶ 27, 387 P.3d 1000 (recognizing the canon of resolving ambiguities to avoid absurd consequences).

It is absurd to allow medical providers (i) to place and leave unnecessary objects in patients by lying to patients about the need for the procedure, and then (ii) to escape liability because the patients do not discover that the procedures were wrongful for more than four years. As the *Chambers* court explained, this interpretation will not "eviscerate the statute of limitations and the statute of repose in cases where any object is intentionally inserted into a patient's body with the intent that it permanently remain in the patient," such as "pacemakers . . . and implants." *Chambers*, 197 S.W.3d at 733. If the object is wrongfully left in the body, but it takes more than four years to discover that the object should not have been there in the first place, the patient should be allowed to bring a claim. It would be absurd to interpret the Utah Legislature to have intended otherwise.

This court can therefore affirm on the alternative ground that the patients have sufficient pled the foreign object exception.

### 3. The Merlo-Schmucker Court Correctly Declined to Dismiss the Negligent Credentialing Claim

The district court adjudicating Ms. Merlo-Schmucker's claims properly did not dismiss her negligent credentialing claim against St. Mark's. Although the Utah Legislature eliminated the cause of action in 2011, this court has been clear that the elimination was not retroactive.

In all three district courts, Dr. Sorensen (but not the hospitals) argued that the negligent credentialing claims should be dismissed. Dr. Sorensen noted that in 2011—after the malpractice here—the Utah Legislature declared that negligent

credentialing was no longer a cause of action. [T.R.328;M.R.201; B.R.240.] The statute provides as follows:

> It is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action.

Utah Code § 78B-3-425.

Only one court ruled on Dr. Sorensen's argument. That court—the court adjudicating Ms. Bright's claims—dismissed her negligent credentialing claim against St. Mark's by applying retroactively the 2011 statute. [B.R.384.] St. Mark's now argues that the court adjudicating Ms. Merlo-Schmucker's claims erred in declining to do the same. (St. Mark's Op. Br. at 39-40.)

But the Merlo-Schmucker court did not err. The statute eliminates the cause of action only for claims that accrued after the statute's effective date, May 10, 2011. Utah Code § 78B-3-425.; *Waddoups v. Noorda*, 2013 UT 64, ¶ 13, 321 P.3d 1108. Because the patients' claims accrued before the statute's effective date, the statute does not eliminate their causes of action for negligent credentialing.

**Conclusion**

This court should affirm the denials of motions to dismiss filed by Dr. Sorensen and the hospitals so these cases can proceed to discovery to uncover the particular details of the fraudulent concealment of more than a thousand unnecessary heart procedures.

DATED this 8th day of May, 2019.

ZIMMERMAN BOOHER

/s/ Troy L. Booher
Troy L. Booher
Beth E. Kennedy

FLEMING, NOLEN & JEZ, L.L.P.
Rand Nolen
David Hobbs

*Attorneys for Appellees*

**Certificate of Compliance**

I hereby certify that:

1. This brief complies with the word limits set forth in the Utah Supreme Court's February 15, 2019 Order because this brief contains 13,913 words, excluding the parts of the brief exempted by Utah R. App. P. 24(g)(2).

2. This brief complies with Utah R. App. P. 21(g) regarding public and non-public filings.

DATED this 8th day of May, 2019.

/s/ Troy L. Booher

**Certificate of Service**

This is to certify that on the 8th day of May, 2019, I caused two true and correct copies of the Brief of Appellees to be served via first-class mail, postage prepaid, with a copy by email, on:

Michael J. Miller
Kathleen J. Abke
Scarlet R. Smith
STRONG & HANNI
102 South 200 East, Suite 800
Salt Lake City, UT 84111
mmiller@strongandhanni.com
kabke@strongandhanni.com
ssmith@strongandhanni.com

*Attorneys for Appellants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

Alan C. Bradshaw
Chad R. Derum
John T. Nelson
MANNING CURTIS BRADSHAW & BEDNAR PLLC
136 E. South Temple, Suite 1300
Salt Lake City, UT 84111
abradshaw@mc2b.com
cderum@mc2b.com
jnelson@mc2b.com

*Attorneys for Appellant IHC Health Services, Inc.*

Eric P. Schoonveld
Tawni J. Anderson
Nathan E. Dorsey
HALL PRANGLE & SCHOONVELD, LLC
111 East Broadway, Suite 700
Salt Lake City, UT 84111
eric@hpslaw.com
tanderson@hpslaw.com
ndorsey@hpslaw.com

Andrew A. Warth
WALLER LANSDEN DORTCH & DAVIS, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
drew.warth@wallerlaw.com

*Attorneys for Appellant St. Mark's Hospital*

/s/ Troy L. Booher

# Addendum A

**The Order of the Court is stated below:**
**Dated:** August 09, 2018 10:29:54 AM **/s/** BARRY LAWRENCE
District Court Judge

**Rhome D. Zabriskie**

**ZABRISKIE LAW FIRM, LLC**

899 North Freedom Blvd, Suite 200

Provo, Utah 84604

Tel: (801) 375-7680

Fax: (801) 375-7686

Email: rhomelawyer@yahoo.com

*Counsel for Plaintiff*

**IN THE THIRD JUDICIAL DISTRICT COURT – SALT LAKE CITY**

**SALT LAKE COUNTY, STATE OF UTAH**

| | | |
|---|---|---|
| **LISA TAPP,**<br><br>Plaintiff,<br><br>v. | )<br>)<br>)<br>)<br>)<br>) | ~~**PROPOSED**~~ **ORDER**<br><br>Case No. 170904956<br>**Judge Barry Lawrence** |

| | | |
|---|---|---|
| **SHERMAN SORENSEN, M.D.; SORENSEN CARDIOVASCULAR GROUP; AND IHC HEALTH SERVICES, INC.**,<br><br>Defendants. | )<br>)<br>)<br>)<br>)<br>)<br>) | |

This matter having come before the Court on May 25, 2018 before the Honorable Judge Barry Lawrence. Rand Nolen, David Hobbs, and Rhome Zabriskie appeared on behalf of Plaintiff Lisa Tapp. Alan Bradshaw and Jack Nelson appeared on behalf of Defendant IHC Health Services, Inc., and Michael Miller and Kathleen Abke appeared on behalf of Defendants Sherman Sorensen and Sorensen Cardiovascular Group. The matter before the Court was a hearing on Defendants' motions to dismiss Plaintiffs' amended complaint.

The Court notes the relevant procedural history. After plaintiff filed her Complaint, a motion to dismiss was filed, followed by a request to file an amended complaint. On February 20, 2018, the Court held argument on the motion to amend and rejected defendants' futility arguments in an Order dated March 7, 2018. After the Amended Complaint, was filed another set of motions to dismiss were filed; they were heard on May 14, 2018. The Court announced its ruling in a telephone conference on May 25, 2018. That ruling is reflected herein; but to the extent that ruling differs from this Order, the oral ruling should control.

Having considered the motions, the Court dismisses the fraud/misrepresentation claims against IHC Health Services, Inc. and the conspiracy claim as to all Defendants. Other than that, the Court denies the motions, leaving the negligence claims against Dr. Sorensen, the negligence claims against IHC Health Services, Inc., and the fraud/misrepresentation claims against Dr. Sorensen.

The Court concludes that it cannot rule on the statute of limitation/repose defense based on the pleadings. Plaintiff is not obligated to plead with particularity in her complaint facts in response to the statute of limitation/repose defense. The Plaintiff is not obligated to meet a heightened pleading requirement relating to facts that would serve to defeat an impending defense. *Zoumadakis v. Uintah Basin Med. Ctr., Inc.*, 2005 UT App 325, ¶ 6, 122 P.3d 891, 893–94 ("the burden of pleading the inapplicability of [privilege] is not initially on the plaintiff, and it is not incumbent on the plaintiff or party filing a complaint to anticipate an affirmative defense which the answer may disclose").

The Court is not persuaded by the Defendants' argument to the contrary, and there is a distinction for cases where the complaint is "facially invalid" or untimely. The Court reads Defendants' cited cases as standing for the proposition that when all the facts necessary to determine an affirmative defense are stated in the complaint, then the affirmative defense can be resolved in a Rule 12 motion. That is not the case here where the facts of fraudulent concealment are not in the complaint and can't be unless the issue is before the Court in full.

In *Tucker v. State Farm Mut. Auto. Ins. Co.*, 2002 UT 54, ¶ 8, 53 P.3d 947, all of the

applicable dates were in the complaint and so the court ruled as a matter of law. There was no assertion of a defense to the defense of statute of limitation, and so it was not inappropriate for the court to rule. Again, it appears to the Court that all facts necessary to decide the Rule 12 motion were in the complaint, which again is a far cry from this case. *Van De Grift v. State*, 2013 UT 11, 299 P.3d 1043 was dismissed on immunity grounds because there is immunity for claims that arise based on fraud and the complaint alleged facts of fraud. *Bivens v. Salt Lake City Corp.*, 2017 UT 67 involved exhaustion of remedies, which is a jurisdictional issue. There the complaint made clear that there was no exhaustion. And, in footnote the *Bivens* court said: "We do not hold today that a plaintiff's complaint must affirmatively plead exhaustion of legal remedies." And in *Lowery v. Brigham Young University*, 2004 UT App 182, the complaint on its face reflected when the plaintiff discovered his claim, which meant that as a matter of law, the discovery rule could not apply and, therefore, the court could rule on the pleadings. None of these cases stand for the proposition that a plaintiff in the first instance has the obligation to state facts necessary to defeat a statute of limitations defense at all, let alone with a degree of particularity. The issue of whether the plaintiff can prove fraudulent concealment required under § 78B-3-404 will have to be based upon what we learn factually in discovery and to be decided at summary judgment or at trial. Accordingly, the Court **DENIES** all of the statute of limitations issues raised by the Defendants.

The Sorensen Defendants argue that Plaintiff's claims should be consolidated into one medical malpractice claim. While the Utah Health Care Malpractice Act does have a broad definition of what a malpractice claim is for procedural purposes, the Court is not aware of any

authority that prevents a plaintiff from asserting alternative facts of fraud or negligence against Dr. Sorensen, and the elements of each would have to be proven at trial. However, the Court notes that it appears that there are multiple claims of negligence and multiple claims of fraud, and The Court will not dismiss those at this time. The plaintiff is certainly entitled to pursue its claims. But ultimately at trial, there will be one negligence claim against Dr. Sorensen and one fraud claim and if the standard of care encompasses various things that's fine, but those are not separate claims. Accordingly, the Court **DENIES** the Sorensen Defendants' motion.

IHC Health Services, Inc.'s motion to dismiss the misrepresentation claims is **GRANTED**. It is important to note that there is a distinction here between the fraud associated with the 2008 surgery and any alleged fraud that took place thereafter that is relevant to statute of limitation/repose. The allegations of IHC Health Services, Inc.'s fraud in inducing Ms. Tapp to have surgery are non-existent. There is nothing but conclusory statements where the plaintiff lumps the "defendants" in together and there is not one fact in the complaint that would support that IHC Health Services, Inc. was somehow involved in a fraud in 2008. There is no fact stated in the complaint that even alleges, let alone with any degree of particularity, as required under Rule 9, U.R.C.P., that IHC Health Services, Inc. was involved in a fraud on Plaintiff in 2008. So that claim against IHC Health Services, Inc. is **DISMISSED**. The fraud claim against Dr. Sorensen will survive and the motion **DENIED**. There are ample allegations of facts supporting this fraudulent inducement theory in 2008 by Dr. Sorensen. But there is absolutely nothing demonstrating any fraud by IHC Health Services, Inc. or any sort of illegal conduct or wrong by IHC Health Services, Inc. and the predicate for a conspiracy claim has not been alleged. There

are no facts alleged against IHC Health Services, Inc. of fraud and conspiracy at the time the surgery was done.

The conspiracy claim, like the fraud claims, is governed by Rule 9 and Rule 9 requires a showing of particularity. *Williams v. State Farm*, 656 P.2d 966 (1982); *Coroles v. Sabey*, 2003 UT App 339, 79 P.3d 974 (2003); *Fidelity Nat. Title Ins. Co. v. Worthington*, 2015 UT App 19, 344 P.3d 156. Having dismissed fraud claims against IHC Health Services, Inc. the Court is compelled to dismiss the conspiracy claim between the Defendants as well. (Having dismissed the underlying predicate for the conspiracy claim (i.e., the fraud claim), there can be no conspiracy claim as a matter of law.). The Court **GRANTS** Defendants' motions as to conspiracy and **DISMISSES** the conspiracy claim against all Defendants.

In summary, the Court:

**GRANTS** IHC Health Services, Inc.'s motion as to the misrepresentation claims and **DISMISSES** the Third; Fifth; and Sixth Claims for Relief against IHC Health Services, Inc.;

**GRANTS** the Defendants' motions as to the conspiracy claim and **DISMISSES** the Seventh Claim for Relief against all Defendants; and otherwise

**DENIES** the motions to dismiss.

*****Executed and entered by the Court as indicated by the date and seal at the top of the first page*****

----------**END OF DOCUMENT**----------

Approved as to form:

ZABRISKIE LAW FIRM

/s/ Jack T. Nelson (signed with permission on behalf of David Hobbs)
David Hobbs

Attorneys for Plaintiff

MANNING CURTIS BRADSHAW & BEDNAR

/s/ Jack T. Nelson
Alan C. Bradshaw
John T. (Jack) Nelson
Attorneys for IHC Health Services, Inc.

STRONG & HANNI

/s/ Jack T. Nelson (signed with permission on behalf of Michael J. Miller)
Michael J. Miller
Attorneys for Sorensen Defendants

**CERTIFICATE OF SERVICE**

I hereby certify that that a true and exact copy of the foregoing has been served on the following via email on 31st day of July 2018:

David Hobbs
ZABRISKIE LAW FIRM, LLC

899 North Freedom Blvd, Suite 200

Provo, Utah 84604

*Attorneys for Plaintiff*

Alan C. Bradshaw
John (Jack) T. Nelson
Manning, Curtis, Bradshaw & Bednar PLLC
136 East South Temple, Suite 1300
Salt Lake City, UT 84111
Phone: 801-363-5678
Fax: 801-364-5678
abradshaw@mc2b.com
jnelson@mc2b.com

*Attorneys for IHC Health Services, Inc.*

Michael J. Miller
Strong & Hanni
102 South 200 East, Suite 800
Salt Lake City, UT 84111
mmiller@strongandhanni.com

*Attorney for Defendants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

/s/ Jack T. Nelson

# Addendum B

**The Order of the Court is stated below:**
**Dated:** June 28, 2018 12:58:05 PM **/s/** PATRICK CORUM
District Court Judge

**Rhome D. Zabriskie**

**ZABRISKIE LAW FIRM, LLC**

899 North Freedom Blvd, Suite 200

Provo, Utah 84604

Tel: (801) 375-7680

Fax: (801) 375-7686

Email: rhomelawyer@yahoo.com

*Counsel for Plaintiff*

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**IN THE THIRD JUDICIAL DISTRICT COURT – SALT LAKE CITY**

**SALT LAKE COUNTY, STATE OF UTAH**

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| | | |
|---|---|---|
| **PIA MERLO-SCHMUCKER,** | ) | **ORDER** |
| | ) | |
| | ) | Case No. 170906130 |
| Plaintiff, | ) | **Judge Patrick Corum** |
| | ) | |
| v. | ) | |
| | ) | |
| **SHERMAN SORENSEN, M.D.;** | | |

**SORENSEN CARDIOVASCULAR GROUP; AND ST. MARK'S HOSPITAL**, )
)
)
Defendants. )
)
)
)

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Following full briefing, this matter came before the Court for hearing and argument on May 1, 2018. On May 18, 2018, Rand Nolen, David Hobbs, and Rhome Zabriskie appeared on behalf of Plaintiff Pia Merlo-Schmucker; Eric Schoonveld and Drew Warth appeared on behalf of Defendant St. Mark's Hospital ("St. Mark's"); and Michael Miller and Kathleen Abke appeared on behalf of Defendants Sherman Sorensen and Sorensen Cardiovascular Group ("Sorensen Defendants") for a telephonic ruling, which is reduced to writing here and is the Order of the Court.

The matters before the Court are St. Mark's Motion to Dismiss Plaintiffs' Amended Complaint and the Sorensen Defendants' Motion to Dismiss Plaintiffs' Amended Complaint. St. Mark's Motion to Dismiss will be GRANTED IN PART AND DENIED IN PART, and the Sorensen Defendants' Motion to Dismiss will be DENIED.

Both St. Mark's and the Sorensen Defendants moved to dismiss all claims in the Amended Complaint under Rule 12(b) on the grounds that all claims therein were barred by the four-year statute of repose found in 78B-3-404(1) and (2) of Utah's Medical Malpractice Act. Those provisions require that claims be brought within four-years of the date of the alleged act,

omission, neglect, or occurrence unless a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct.

It is not clear from the Amended Complaint whether any Defendant acted affirmatively within the meaning of the statute to fraudulently conceal anything. The word "affirmatively" was presumably and advisedly put into the statute—78B-3-404(1)—with meaning, and it appears to have a meaning different from the common law. Under the statute, some affirmative act of concealment is necessary to maintain an otherwise time-barred action. Defendants' argument that inaction or omission by a defendant is not sufficient to overcome the time bar appears to be well taken.

That being said the Court is not convinced this issue is procedurally ripe at the Rule 12(b) stage and questions whether the Plaintiff is obligated to combat an affirmative defense, however likely or inevitably it is to be raised, in its initial pleading.

The Defendants have presented cases that clearly indicate that the Court has discretion to address these issues under a 12(b) motion, however those cases are distinguishable in the Court's view. *Roth v. Pederson* was a judgment on the pleadings so the procedural context is similar, but, based on what the Court can tell from the opinion, the relevant allegations in the *Roth* complaint regarding fraudulent concealment were extremely sparse and entirely conclusory. 2009 UT App 313, 2009 WL 3490974 (unpublished). That is not the case here; the allegations have more detail and more substance than what was apparently pled in *Roth. Tucker v. State Farm Mut. Auto. Ins. Co.* is more on point than *Roth* as it was a Rule 12(b) motion, converted into a Rule 56 Motion. *Tucker* clearly gives a court discretion to entertain statute of limitations defenses in a motion to

dismiss but did so under limited circumstances, which are not present here. 2002 UT 54, ¶ 8, 53 P.3d 947. In *Tucker* the plaintiff did not appear to offer any argument to counter the application of the statute of limitations and there did not appear to be any dispute as to whether it would have in fact barred the action, the plaintiff only argued that issue should not have be decided at that stage. It is a close call, but the Court feels the Plaintiff in this case has done enough to move her case into the next stage. Accordingly, the Court **DENIES** Defendants' Motions on the statute of limitations/repose issue.

Defendants also seek dismissal of Plaintiff's fraud-based claims for failure to allege them with particularity as required by Rule 9(c). First, as to Plaintiff's claim for negligent misrepresentation, the Court finds the Amended Complaint contains no particular allegations as to misrepresentations made by St. Mark's Hospital. Similarly, Plaintiff's fraud and fraudulent concealment claims (as opposed to the exception to the statute of repose) also fail as to St. Mark's for failing to satisfy Rule 9(c). Accordingly, the Court **GRANTS** St. Mark's Hospital's motion and **DISMISSES** the negligent misrepresentation (Count III), fraudulent concealment (Count V), and fraud (Count VI) claims as to St. Mark's Hospital. As to the Sorensen Defendants, the Court finds the Amended Complaint alleges with particularity the fraud-based claims. Accordingly, the Court **DENIES** the motions to dismiss the negligent misrepresentation, fraudulent concealment, and fraud claims as to the Sorensen Defendants. Further, the Court finds the Amended Complaint adequately alleges civil conspiracy and therefore **DENIES** the motions to dismiss the civil conspiracy (Count VII) claims as to all Defendants.

The Sorensen Defendants further argue that all of Plaintiff's claims should be dismissed under the doctrine of claim preclusion due to the dismissal of the separate *qui tam* action, which

involved claims by a relator under the federal False Claims Act. That dismissal is currently on appeal with the Tenth Circuit. I find that the issues in the *qui tam* and this action are not identical. Further, the parties are not identical, the parties are not in privity, and there has not been a final judgment in the *qui tam* action. Accordingly, the Court **DENIES** the Sorensen Defendants' motion to dismiss all claims under the doctrine of claim preclusion.

Finally, the Sorensen Defendants argue that Plaintiff's claims for negligence, negligent misrepresentation, fraud, and civil conspiracy are not cognizable as claims distinct from Plaintiff's medical negligence claim. While the Utah Health Care Malpractice Act does define a malpractice action to include any action against a health care provider, whether in contract, tort, breach of warranty, wrongful death, or otherwise, based upon alleged personal injuries relating to or arising out of health care rendered or which should have been rendered by the health care provider, it does so to identify the causes of action governed by the Act. But the Act does not foreclose a plaintiff from pleading different causes of action or create one omnibus cause of action. Accordingly, the Court **DENIES** the Sorensen Defendants' motion. The Court's signature appears at the top of the first page of this order.

*****Executed and entered by the Court as indicated by the date and seal at the top of the first page*****

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# Addendum C

IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

| | |
|---|---|
| JOHANNAH BRIGHT,<br><br>Plaintiff,<br><br>vs.<br><br>SHERMAN SORENSEN, M.D.; SORENSEN CARDIOVASCULAR GROUP; AND ST MARK'S HOSPITAL,<br><br>Defendants. | RULING AND ORDER RE PENDING MOTIONS TO DISMISS<br><br>Case No. 170906790<br><br>June 20, 2018<br><br>Judge Laura S. Scott |

Before the court is the *Motion to Dismiss Plaintiff's First Amended Complaint* filed by Defendants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group (collectively Sorensen Defendants) and the *Motion to Dismiss Amended Complaint* filed by Defendant St. Mark's Hospital. The court heard oral argument on the Motions on May 1, 2018 and took them under advisement. Having considered the briefing, arguments of counsel, and applicable law, the court now issues the following Ruling and Order:

## ALLEGATIONS OF THE FIRST AMENDED COMPLAINT

1. This case involves surgery to close a patent foramen ovale (PFO), which is a hole in the heart that occurs after birth when the foramen ovale fails to close.[1] According to the First Amended Complaint, approximately 25% of the healthy population have a PFO and will never require any treatment or evaluation. PFO closure is not medically necessary unless there is a confirmed diagnosis of recurrent cryptogenic stroke or transient ischemic attack (TIA).[2]

[1] The second type of hole is called an atrial septal defect (ASD), which is considered a birth defect.

[2] *See* First Amended Complaint, ¶¶ 10-14, which was filed on December 21, 2017.

2. Dr. Sorensen is a cardiologist who was practicing interventional cardiology. Dr. Sorensen had privileges at St. Mark's.[3]

3. From approximately 2002 to 2012, Dr. Sorensen performed more than 4,000 PFO and ASD closures, many of those at St. Mark's. He performed these procedures at a rate that dwarfed the rest of the country.[4]

4. St. Mark's was on notice that Dr. Sorensen was engaged in the practice of regularly performing unnecessary and invasive PFO closures on his patients because of the sheer volume of the procedures and complaints from other practitioners and employees.[5]

5. Also, during the hiring and credentialing process, Dr. Sorensen told St. Mark's how and under what conditions he would perform PFO and ASD closures, including that he would perform closures on patients who did not have recurrent cryptogenic strokes.[6]

6. The catheterization lab at St. Mark's became financially dependent on Dr. Sorensen's practice. Consequently, despite knowing that Dr. Sorensen was performing medically unnecessary closures, St. Mark's continued to court his business, provide a platform and assistance to him, and advertise and promote Dr. Sorensen's practice.[7]

7. The Sorensen Defendants and St. Mark's created false statements and documents to conceal the fact that Dr. Sorensen was performing medically unnecessary closures, including medical charts.[8]

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[3] *Id.*, ¶ 16.

[4] *Id.*

[5] *Id.*, ¶ 17.

[6] *Id.*, ¶ 18.

[7] *Id.*, ¶¶ 22, 23.

[8] *Id.*, ¶ 20.

8. In 2007, Plaintiff Johannah Bright was referred to Dr. Sorensen because she was experiencing migraines and a transesophageal echocardiogram showed right to left shunting across the atrial septum. She was seen by Dr. Sorensen on September 21, 2007 at his offices, where she underwent a transthoracic echocardiogram (TTE) with bubble study and transcranial Doppler study (TCD).[9]

9. On October 1, 2007, Western Neurological Associates performed a brain MRI on Ms. Bright, which was interpreted as "normal contrast-enhanced MRI of the brain."[10]

10. On November 28, 2007 at a follow-up office visit, Dr. Sorensen did not recommend closure because "she [did] not have risk stratification features [for stroke] other than migraine.[11]

11. On November 4, 2009, Ms. Bright returned to Dr. Sorensen for a second consultation. Dr. Sorensen's neurologic exam was not comprehensive. Contrary to his 2007 note, Dr. Sorensen's 2009 note states that Ms. Bright "has high risk features for stroke" and "an interatrial septal aneurysm."[12]

12. To induce her to undergo the PFO closure procedure, Dr. Sorensen told Ms. Bright that she had a high risk of a debilitating stroke and that the PFO closure would be effective and was medically necessary in order to prevent strokes. Dr. Sorensen also provided Ms. Bright with a PFO handout that contained fraudulent statements and unsupported data.[13]

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[9] *Id.*, ¶ 25.

[10] *Id.*, ¶ 26.

[11] *Id.*, ¶ 27.

[12] *Id.*, ¶ 28.

[13] *Id.*, ¶ 34.

13. Dr. Sorensen's statements were made with the intent to induce Ms. Bright to undergo the unnecessary procedure. Ms. Bright did not know the statements were false or misleading. And she relied on these statements in agreeing to undergo the procedure.[14]

14. On December 15, 2009, Ms. Bright underwent the PFO closure procedure.[15]

15. On March 18, 2010 and June 28, 2018, Ms. Bright had follow-up tests in Dr. Sorensen's office.[16]

16. On or about June 27, 2011, Dr. Sorensen's privileges at another hospital were suspended. St. Mark's CEO Steve Bateman and physician liaison Nikki Gledhill were aware of the suspension.[17]

17. St. Mark's knew about Dr. Sorensen's practices but did not inform Ms. Bright that she may have had a medically unnecessary surgery and chose not to reimburse her or her insurance company for the procedure. To this day, St. Mark's has actively concealed its knowledge about Dr. Sorensen's practices from patients, third party payors, and the public.[18]

18. Because of their fraudulent statements and omissions, Ms. Bright only learned of Defendants' misconduct as a result of lawyer advertising.[19]

19. Ms. Bright has suffered significant damages, including undergoing an unnecessary surgical procedure and hospital stay, paying significant medical expenses, physical pain, and emotional anguish.[20]

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[14] *Id.*, ¶ 34.

[15] *Id.*, ¶ 29.

[16] *Id.*, ¶¶ 30, 31.

[17] *Id.*, ¶ 19.

[18] *Id.*, ¶ 35.

[19] *Id.*, ¶ 37.

[20] *Id.*, ¶ 38.

## RULING AND ORDER

***Rule 12(b) Standard***

On a rule 12(b)(6) motion, the court determines whether the plaintiff has alleged enough facts in the complaint to state a cause of action.[21] The court presumes "the factual allegations in the complaint are true and . . . draw[s] all reasonable inferences in the light most favorable to the plaintiff."[22] The court's sole concern is "the sufficiency of the pleadings, [and] not the underlying merits of [the] case."[23] Thus, a plaintiff's claims are subject to dismissal only when the allegations of the complaint "clearly demonstrate that the plaintiff does not have a claim."[24]

***Collateral Estoppel (Issue Preclusion)***

The Sorensen Defendants first argue that Ms. Bright's claims are barred by collateral estoppel because her allegations "are the same basic allegations asserted in the *qui tam* case and are based on the same facts and issues." As discussed at the hearing, the court is not persuaded by this argument because the issue decided in the qui tam case – whether Defendants "submitted objectively false claims for payment" – is not identical to the issues presented in this case. Nor have the Sorensen Defendants established the other elements of collateral estoppel, *i.e.*, that the parties are the same or in privity with each other or that the issues in this case have been completely, fairly, and fully litigated in the *qui tam* case.[25]

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[21] *Alvarez v. Galetka*, 933 P.2d 987, 989 (Utah 1997).

[22] *Commonwealth Prop. Advocates, LLC v. Mortg. Elec. Registration Sys., Inc.*, 2011 UT App 232, ¶ 16, 263 P.3d 397, 404.

[23] *Oakwood Vill. LLC v. Albertsons, Inc.*, 2004 UT 101, ¶ 8, 104 P.3d 1226, 1230 (citing *Alvarez*, 933 P.2d at 989).

[24] *Alvarez* at 989.

[25] *Gunmundson v. Del Ozone*, 2010 UT 33, ¶ 9, 232 P.3d 1059, 1067.

*Statue of Repose*

Defendants argue that Ms. Bright's claims are barred by the statute of repose set forth in the Utah Medical Malpractice Act. As set forth below and applying the motion to dismiss standard, the court is unable to conclude at this time that the statute of repose was not tolled as result of Defendants' alleged affirmative acts to fraudulently conceal their misconduct.[26]

"As a general rule, a statute of limitations begins to run upon the happening of the last event necessary to complete the cause of action."[27] Once a statute begins to run, a plaintiff must file her claim before the limitations period expires or the claim will be barred.[28] However, there are "two narrow settings in which a statute of limitations may be tolled until the discovery of facts forming the basis for the cause of action."[29] "The first setting . . . involves situations in which a relevant statute of limitations, by its own terms, mandates application of the discovery rule."[30] This setting is referred to as the statutory discovery rule. The second setting, which is referred to as the equitable discovery rule, applies *only* where a statute of limitations does not, by its own terms, already account for such circumstances."[31]

As a preliminary matter, the parties appear to agree that Ms. Bright's claims are subject to the statute of limitations found in the Utah Health Care Malpractice Act, which contains a statutory discovery rule. The Act also includes a statue of repose, which bars claims commenced more than four years after the date of the alleged act, omission, neglect, or occurrence"

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[26] At the hearing, Ms. Bright argued the foreign object exception of § 78B-3-404(2)(A) also applies. The court disagrees. The catheter was not "wrongly left" within her body. And there is no allegation that Ms. Bright did not know that it was placed in her body as part of the closure procedure.

[27] *Myers v. McDonald,* 635 P.2d 84, 86 (Utah 1981) (citation and internal quotation marks omitted).

[28] *See id.*

[29] *Russell Packard Dev., Inc. v. Carson,* 2005 UT 14, ¶ 21, 108 P.3d 741, 746

[30] *Id.*

[31] *Id.* at ¶ 25

regardless of when a plaintiff discovers her injury.[32] However, "in an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has *affirmatively acted to fraudulently conceal the alleged misconduct*, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs."[33] Thus, "[i]n medical malpractice cases, the running of the statute of limitations [can only be] tolled when a patient has been prevented from discovering the malpractice by the health care provider's affirmative acts of fraudulent concealment."[34]

Defendants first argue Ms. Bright failed to plead fraudulent concealment with particularity under Rule 9(c). The court is not convinced that Rule 9(c) requires a plaintiff to plead defensive fraudulent concealment in her complaint in anticipation that a defendant may assert the statute of limitations or statute of repose in a motion to dismiss. With the exception of *Roth v. Pedersen* discussed further below, the appellate courts in the cases cited by Defendants were reviewing the district court's grant of summary judgment, not a dismissal under Rule 12(b).[35] The court accordingly rejects this argument at this juncture.

Turning to their primary argument, as the court understands it from the briefing and oral argument, Defendants assert the statute of repose was not tolled because Ms. Bright has not alleged "active" concealment. "Fraudulent concealment requires that one with a legal duty or

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[32] Utah Code Ann. § 78B-3-404(1).

[33] Utah Code Ann. § 78B-3-404(2) (emphasis added).

[34] *Roth v. Joseph*, 2010 UT App 332, ¶ 31, 244 P.3d 391, 398 (emphasis added) (citing *Chapman v. Primary Children's Hosp.*, 784 P.2d 1181, 1184–87 (Utah 1989) (applying statute)).

[35] *See Berenda v. Langford*, 914 P.2d 45 (Utah 1996) (summary judgment); *Chapman v. Primary Children's Hosp.*, 784 P.2d 1181 (Utah 1989) (summary judgment); *Roth v. Joseph*, 2010 UT App 332, 244 P.3d 391 (summary judgment); *see also Jensen v. IHC Hosps., Inc.*, 944 P.2d 327, 333 (Utah 1997) (motion in limine and trial).

obligation to communicate certain facts remain silent or otherwise act to conceal material facts known to him."[36] Defendants do not dispute that a health care provider is required to disclose "material information concerning the patient's physical condition. This duty to inform stems from the fiduciary nature of the relationship and the patient's right to determine what shall or shall not be done with his body."[37] But, Defendants argue, the statute's inclusion of the phrase "affirmatively acted" means that silence or "pure, uninvited non-disclosure" is not enough. According to Defendants, Ms. Bright must have "directly engaged with each defendant that she accuses of affirmatively fraudulently concealing her injury from her, and then the individual defendant must have done something affirmative to prevent her from discovering her legal injury." Defendants also appear to argue the "engagement" and "affirmative" responsive act must have occurred after the surgery.

Defendants' argument finds some support in the holding in *Roth v. Pedersen*, a short memorandum decision. The Utah Court of Appeals affirmed the grant of the motion for judgment on the pleadings because the plaintiff "failed, as required by the Act, to commence litigation within two years of discovery of his legal injury, which occurred, at the latest, in May 2006" when he initiated legal action against his general surgeon. The Court then addressed the plaintiff's alternative argument regarding fraudulent concealment. Because the plaintiff did not allege that he consulted with the defendant about the surgery or that the defendant provided him with information that misrepresented or concealed his involvement in the surgery, the Court affirmed the district court's dismissal of his claim "for failure to plead fraud with sufficient particularity."[38] In *Roth*, the plaintiff had inquiry notice. There was no such notice here.

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[36] *Jensen,* 944 P.2d at 333.

[37] *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) (citations and internal quotation marks omitted).

[38] *Pedersen v. Roth*, 2009 UT App 313.

Even if the court were to ultimately rule the fraudulent concealment had to occur after the surgery, the court is not convinced that "affirmatively acted" in the context of this case means that Ms. Bright must have "directly engaged" with the Sorensen Defendants and St. Mark's *if* she can demonstrate they were in possession of specific facts they had a duty to disclose and the disclosure of such facts would have put her on notice of the alleged misconduct.[39] For St. Mark's, such facts may include Dr. Sorensen's suspension or any other specific information it may have had regarding Dr. Sorensen's alleged misconduct in connection with Ms. Bright's surgery. Finally, with respect to Dr. Sorensen, Ms. Bright has alleged some affirmative acts that occurred after the surgery, including his follow-up treatment and billing.

Defendants also argue that Ms. Bright has failed to allege she conducted any investigation or inquiry into the medical care she received from Dr. Sorensen, or that her investigation was thwarted by any alleged affirmative act on the part of Defendants. A plaintiff seeking to save her claims under the discovery rule must demonstrate she exercised reasonable diligence in not bringing her claims in a timely manner. This is a fact-intensive matter for the fact finder to ascertain except in only "the clearest of cases."[40] In determining reasonable diligence, the fact finder considers the "difficulty a plaintiff may have in recognizing and diligently discovering a cause of action when a defendant affirmatively and fraudulently conceals it."[41] Here, Ms. Bright's claims relate to an allegedly unnecessary surgery which did not have an adverse outcome or any complications. And, unlike in the cases cited, Defendants have failed to

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[39] St. Mark's argues that it has no duty to "analyze and disclose judgments by a treating physician, particularly when no physical complication is alleged" or to "investigate all procedures performed in its cath lab for medical necessity." The court does not necessarily disagree. But the fact that St. Mark's may not have had a duty to analyze or investigate does not necessarily mean that it did not have a duty to disclose specific information it may have had related to Ms. Bright's surgery.

[40] *Russell Packard Dev., Inc.*, at ¶ 39.

[41] *Berenda*, 914 P.2d at 54.

identify any facts that Ms. Bright had knowledge of that would have put her on inquiry notice that the surgery was medically unnecessary.[42] As the Utah Supreme Court observed in *Colosimo*, Ms. Bright cannot be expected to inquire about the existence of a claim that is entirely concealed from her when there is nothing to put her on inquiry notice. Accordingly, the court is unable to conclude that her "failure to investigate possible misconduct" makes this one of the "clearest of cases" that warrants dismissal pursuant to a motion to dismiss.[43]

Having rejected Defendants' statute of repose arguments in light of the motion to dismiss standard, the court now turns to the other possible grounds for dismissing Ms. Bright's claims.

***Ms. Bright's Negligence Claim (Second Claim for Relief)***

Defendants argue that Ms. Bright's common law negligence claim is duplicative of her negligence (health care malpractice) claim. The court agrees because Ms. Bright has not identified a common law or statutory duty that Dr. Sorensen or St. Mark's owed her that is independent from the duty that arose from their provider-patient relationship. Accordingly, Ms. Bright's Second Claim for Relief should be dismissed because it fails to state a claim upon which relief may be granted.

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[42] *See Daniels v. Gamma West Brachytherapy, LLC*, 2009 UT 66, ¶ 30, 221 P.3d 256 ("it seems somewhat incongruous that an injured person must commence a malpractice action prior to the time he knew, or reasonably should have known, of his injury and right of action."); *Russell Packard Dev., Inc.* at ¶ 28 ("to permit one practicing a fraud and the concealing it to plead the statute of limitations when, in fact, the injured party did not know of and could not with reasonable diligence have discovered the fraud" would be "not only subversive of good morals, but also contrary to the plainest principles of justice"); *Foil v. Ballinger*, 601 P.2d 144, 147 (Utah 1979) (the law ought not to be construed to destroy a right of action before a person even becomes aware of the existence of that right) (all internal citations omitted).

[43] *See Day v. Meek*, 1999 UT 28, ¶ 21, 976 P.2d 1202 (interpreting statute in light of obvious unfairness of unreasonably barring claims that have been fraudulently concealed).

***Ms. Bright's Negligent Credentialing Claim (Fourth Claim for Relief)***

In support of her negligent credentialing claim against St. Mark's, Ms. Bright alleges that St. Mark's had a duty to "periodically monitor and review the qualifications and competency of its medical staff" and that it breached this duty, presumably in connection with its granting of privileges to Dr. Sorensen. However, "[i]t is the policy of this state that the question of negligent credentialing, as applied to health care providers in malpractice suits, is not recognized as a cause of action."[44] Accordingly, Ms. Bright's Fourth Claim for Relief should be dismissed because it fails to state claim upon which relief may be granted.

***Fraudulent Non-Disclosure or Concealment (Fifth Claim for Relief)***

To prevail on her fraudulent non-disclosure or concealment claim, "a plaintiff must prove the following three elements: (1) the nondisclosed information is material, (2) the nondisclosed information is known to the party failing to disclose, and (3) there is a legal duty to communicate."[45] Ms. Bright alleges Defendants "owed a duty [to] disclose important facts, such as the medical necessity of [her] medical care." This is simply the converse of her primary fraud and negligent misrepresentation allegation, *i.e.,* Dr. Sorensen told her the procedure was medically necessary because she had a high risk of stroke. Ms. Bright also fails to identify a duty different or separate from the duty that arises from the provider-patient relationship. Thus, the court concludes her fraudulent concealment claim against the Sorensen Defendants is subsumed within her malpractice, fraud, and/or negligent misrepresentation claims.

With respect to St. Mark's, the court agrees that Ms. Bright fails to state a claim upon which relief can be granted. She does not plead any facts from which the court may infer that St.

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[44] Utah Code Ann. §78B-3-425.

[45] *Hermansen v. Tasulis*, 2002 UT 52, ¶ 24, 48 P.3d 235

Mark's knew that her particular surgery was not medically necessary prior to the surgery.[46] And while St. Mark's alleged failure to notify patients that Dr. Sorensen's privileges had been suspended for performing unnecessary closure procedures may be sufficient to defeat a motion to dismiss based on the statute of repose, it cannot form the basis of an affirmative fraudulent concealment claim. Indeed, Ms. Bright could not have relied on St. Mark's silence regarding the suspension in agreeing to the surgery because the suspension happened after her surgery. Accordingly, the court dismisses Ms. Bright's fraudulent concealment claim.[47]

***Ms. Bright's Other Claims Are Not Subsumed into a Single Malpractice Claim***

Defendants argue Ms. Bright's other claims should be dismissed because they are subsumed into her First Claim for Relief for Negligence – Health Care Malpractice. Specifically, Defendants argue that all alleged breaches of duty in a provider-patient relationship are "properly actionable under the Utah Health Care Malpractice Act and not as separate claims." They base this argument on § 78B-3-403, which defines a malpractice action against a health care provider as "any action against a health care provider, whether in contract, tort, breach of warranty, wrongful death, or otherwise, based upon alleged personal injuries relating to or arising out of health care rendered or which should have been rendered by the health care provider."[48] Although the court agrees that Ms. Bright's negligence claim is subsumed within her malpractice claim, the court is not otherwise persuaded that the Act prevents Ms. Bright from bringing her negligent misrepresentation, fraud, and civil conspiracy claims, which do not necessarily depend upon an "alleged breach of duty to provide accurate information concerning the necessity of

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[46] In general, a hospital does not owe an independent duty to obtain a patient's informed consent to treatment. *See Buu Nguyen v. IHC Med. Servs., Inc.*, 2102 UT App 288, ¶ 11, 288 P.3d 1084.

[47] Additionally, if there is other material information that Defendants failed to disclose prior to her surgery, Ms. Bright has not sufficiently identified it as required by Rule 9(c) of the Utah Rules of Civil Procedure, which is discussed further below.

[48] Utah Code Ann. § 78B-3-403.

medical care relating to the PFO closure procedure" as argued by Defendants. Indeed, duty is not an element of a fraud, negligent misrepresentation, or civil conspiracy claim.

***Rule 9(c)'s Particularity Requirement for Affirmative Claims***

Ms. Bright's fraud, misrepresentation, and civil conspiracy claims against Defendants implicate Rule 9(c) of the Utah Rules of Civil Procedure, which requires a plaintiff to state with particularity the circumstances constituting the fraud. Pleadings satisfy this standard only if they include a sufficiently clear and specific description of the facts underlying the claim,[49] including the who, what, when, where, and how.[50] Defendants argue Ms. Bright has failed to satisfy this standard and, consequently, these claims should be dismissed. As discussed further below in connection with each claim, the court concludes that Ms. Bright has complied with Rule 9(c).

*Negligent Misrepresentation and Fraud Claims (Third and Sixth Claims for Relief)*

With respect to her fraud and negligent misrepresentation claims, Ms. Bright must prove "(1) that a representation was made (2) concerning a presently existing material fact (3) which was false and (4) which the representor either (a) knew to be false or (b) made recklessly, knowing that there was insufficient knowledge upon which to base such a representation, (5) for the purpose of inducing [her] to act upon it and (6) that [she], acting reasonably and in ignorance of its falsity, (7) did in fact rely upon it (8) and was thereby induced to act (9) to [her] injury and damage."[51]

The court concludes Ms. Bright has pled her fraud and negligent misrepresentation claims with sufficient particularity as to Dr. Sorensen. Ms. Bright alleges the "who" (Dr. Sorensen), "what" (false statement that she had a high risk of debilitating stroke and PFO closure

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[49] *Carlton v. Brown*, 2014 UT 6, ¶ 8, 323 P.3d 571.

[50] *Webster v. JP Morgan Chase Bank, NA*, 2012 UT App 321, ¶19, 290 P.3d 930.

[51] *Fid. Nat. Title Ins. Co. v. Worthington*, 2015 UT App 19, ¶ 10, 344 P.3d 156, 159.

was necessary to prevent strokes), "where" (Dr. Sorensen's offices), "when" (November 4, 2009), and "how" (Dr. Sorensen told her the false statement directly and provided her with a handout containing false statements and data). She sets forth how she reasonably relied on the allegedly false statements in deciding to have the surgery and how she was damaged thereby.

In contrast, Ms. Bright has not pled these claims with sufficient particularity with respect to St. Mark's. It does not appear St. Mark's made any statements to Ms. Bright prior to the surgery. And to the extent her claims against St. Mark's are based on a failure to disclose, Ms. Bright has not alleged facts from which the court can infer that St. Mark's owed a duty to her prior to surgery or that she somehow relied on St. Mark's silence in deciding to have the surgery.

*Civil Conspiracy (Seventh Claim for Relief)*

With respect to her civil conspiracy claim, Ms. Bright must prove "(1) a combination of two or more persons, (2) an object to be accomplished, (3) a meeting of the minds on the object or course of action, (4) one or more unlawful, overt acts, and (5) damages as a proximate result thereof."[52] In addition, Ms. Bright must prove an underlying tort."[53]

The court determines that Ms. Bright has satisfied Rule 9(c) because she has sufficiently identified the co-conspirators (the Sorensen Defendants and St. Mark's), the object to be accomplished (increasing income for the Sorensen Defendants and profits for St. Mark's by performing medically unnecessary surgeries), the meeting of the minds (discussing during hiring and credentialing how Dr. Sorensen would perform the closures and under what circumstances, ignoring complaints by other physicians, providing special treatment to Dr. Sorensen, and advertising and promoting Dr. Sorenson's closure practice), the unlawful, over acts (making

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[52] *Fid. Nat. Title Ins. Co.*, 2015 UT App at ¶ 16 (citing *Israel Pagan Estate v. Cannon,* 746 P.2d 785, 790 (Utah Ct.App.1987)).

[53] *Puttuck v. Gendron*, 2008 UT App 362, ¶ 21, 199 P.3d 971, 978.

fraudulent statements, performing medically unnecessary closures at St. Mark's, falsifying records), and the damages (undergoing and paying for a medically unnecessary surgery and follow-up treatment). Ms. Bright identifies the underlying tort as fraud.[54]

## CONCLUSION

For the reasons set forth above, the Motions are granted in part and denied in part.

With respect to the Sorensen Defendants, their Motion is GRANTED as to (a) the Second Claim for Relief (Negligence) because it is duplicative of the First Claim for Relief (Negligence – Malpractice) and (b) the Fifth Claim for Relief (Fraudulent Non-Disclosure/Concealment) because it is subsumed within other claims and/or she has failed to plead it with the requisite specificity. The Motion is DENIED as to all other claims against the Sorensen Defendants.

With respect to St. Mark's, its Motion is GRANTED as to (a) the Second Claim for Relief (Negligence) because it is duplicative, (b) the Fourth Claim for Relief (Negligent Credentialing) because it is not recognized in Utah, and (c) the Third and Sixth Claims for Relief (Negligent Misrepresentation and Fraud) because Ms. Bright has not pled them with particularity. It is also GRANTED as to the Fifth Claim for Relief (Fraudulent Non-Disclosure/Concealment) because it is subsumed within other claims and/or she has failed to plead it with particularity. The Motion is DENIED as to all other claims against St. Mark's.

## RULE 16 SCHEDULING CONFERENCE

At counsel's convenience, they should contact the court's judicial team to schedule a Rule 16 scheduling conference to discuss a scheduling order and the status of the other pending cases.

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[54] Although the court has dismissed the fraud claim against St. Mark's, this does not necessarily mean that a civil conspiracy claim based on a fraud also must be dismissed. *See, e.g., Israel Pagan Estate v. Cannon*, 746 P.2d 785, (because defendant did not, by its own actions, defraud plaintiff or authorize another to do so, defendant's liability can only be established by proving that it was engaged in a conspiracy to defraud).

SO ORDERED.

Dated this 20th day of June, 2018

Judge Laura S. Scott
Third Judicial District Court

CERTIFICATE OF NOTIFICATION

I certify that a copy of the attached document was sent to the following people for case 170906790 by the method and on the date specified.

MANUAL EMAIL: KATHLEEN J ABKE kabke@strongandhanni.com
MANUAL EMAIL: TAWNI J ANDERSON tanderson@hpslaw.com
MANUAL EMAIL: NATHAN E DORSEY ndorsey@hpslaw.com
MANUAL EMAIL: DAVID HOBBS david_hobbs@fleming-law.com
MANUAL EMAIL: MICHAEL J MILLER mmiller@strongandhanni.com
MANUAL EMAIL: RAND PATRICK NOLEN rand_nolen@fleming-law.com
MANUAL EMAIL: ERIC P SCHOONVELD eric@hpslaw.com
MANUAL EMAIL: ANDREW A WARTH drew.warth@wallerlaw.com
MANUAL EMAIL: RHOME D ZABRISKIE rhomelawyer@yahoo.com

Date: 06/20/2018

/s/ EMILY AGUILAR-CUESTA

Deputy Court Clerk

# Addendum D

**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

*Counsel for Plaintiff*

**IN THE THIRD JUDICIAL DISTRICT COURT – SALT LAKE CITY**

**SALT LAKE COUNTY, STATE OF UTAH**

| | |
|---|---|
| **LISA TAPP,**<br><br>Plaintiff,<br><br>v.<br><br>**SHERMAN SORENSEN, M.D.; SORENSEN CARDIOVASCULAR GROUP; AND IHC HEALTH SERVICES, INC.,**<br><br>Defendants. | **FIRST AMENDED COMPLAINT**<br>**(Tier 3 Filing)**<br><br>**(Jury Demanded)**<br><br>Case No. 170904956<br>**Judge Barry Lawrence** |

**COMES NOW** Plaintiff, by and through counsel, and hereby complain for causes of action against the above-captioned Defendants, alleging as follows:

## PARTIES, JURISDICTION, AND VENUE

1. Plaintiff Lisa Tapp is, and at all relevant times has been, a resident of Salt Lake County, State of Utah.

2. Defendant SHERMAN SORENSEN, M.D. was, at all relevant times, a licensed physician providing health care services in Salt Lake County, State of Utah.

3. Defendant SORENSEN CARDIOVASCULAR GROUP (SCG), was at all material times, a Utah professional corporation in the business of providing health care services to residents of Utah. Defendant SCG's principal place of business is located at 5169 Cottonwood Street, No. 610, Murray, Utah. Defendant Sherman Sorensen owned and operated SCG as his primary medical practice.

4. Defendant IHC Health Services, Inc. (IHC) is a not-for-profit corporation based in Salt Lake City, Utah with its principal place of business and corporate office at 36 S. State Street Salt Lake City, UT 84111. IHC operates several healthcare facilities under d/b/a's, including Intermountain Medical Center, which has its principal place of business and corporate office at 5100 South State Street, Murray, Utah. IHC's Registered Agent for Service is Anne D. Armstrong, 36 South State St. Suite 2200, Salt Lake City, UT 84111.

5. Upon information and belief, at all material times, each of the Defendants were, or may have been, an agent, servant, employer, employee, joint venture, partner, and/or alter ego of one or more of each of the remaining Defendants, and were at all times acting within the purpose and scope of such agency, servitude, joint venture, alter ego, partnership, or employment, and with the authority, consent, approval, and/or ratification of each remaining Defendant.

6. At all material times, Defendants were health care providers within the meaning of the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-401 et seq., and each Defendant provided health care services to Lisa Tapp.

7. This Court has jurisdiction over this action pursuant to Utah Code Ann. § 78A-5-102.

8. Venue is proper in this Court pursuant to Utah Code Ann. § 78B-3-307.

9. In bringing this action, Plaintiff complied with all statutory requirements regarding pre-litigation review of this matter as set forth in the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-416.

## BACKGROUND

10. This case is one of more than a thousand cases that are presently working their way through the prelitigation process, which involve the medically unnecessary heart surgery by Dr. Sherman Sorensen related to two kinds of holes in the heart. One is called an atrial septal defect (ASD), and the other is a patent foramen ovale (PFO). Both are holes in the wall of tissue (septum) between the left and right upper chambers of the heart (atria). An ASD is considered a birth defect and is a failure of the septal tissue to form between the atria, PFO's can only occur after birth when the foramen ovale fails to close.[1]

11. Life threatening ASD's are generally discovered at birth and corrected immediately. However, there are billions of adults who have small openings between the left and right atriums of their hearts.[2] The foramen ovale is an opening located in the wall separating the two upper chambers of the heart, the atrial septum, which is used during fetal circulation to redirect blood through the heart. In 75% of the population, the foramen ovale closes at birth when increased blood pressure on the left side of the heart forces the opening to close. In those cases, where the foramen ovale does not close at birth, a patent foramen ovale (PFO) results.

[1] Dr. Sorensen at times earlier in his career referred to these two conditions interchangeably, but for insurance reimbursement purposes decided that all PFO's were ASD's later in his practice. Either way, and no matter what he called them, he closed holes indiscriminately and without medical justification on thousands of people including the Plaintiff.

12. Approximately 25% of the healthy population have a PFO and will never require any treatment or evaluation. Apart from extremely rare cases, patients with a PFO remain completely unaware of the presence of the PFO because it's almost never associated with symptoms. Persistent patency of the foramen ovale is considered a normal anatomic variation.

13. Only if a patient has a recurrence of cryptogenic (originating from unexplained causes) stroke or transient ischemic attack (TIA), likely due to paradoxical embolization through a PFO, and despite optimal medical therapy, may it be appropriate to close the PFO. Generally, this closure is performed through a percutaneous surgical procedure. In the percutaneous procedure, a patient undergoes a cardiac catheterization to determine the size and location of the PFO.

14. There has long been general agreement in the medical community—as far back as 2003—that PFO closure is not medically necessary, except in the limited circumstances where there is a confirmed diagnosis of a recurrent cryptogenic stroke or TIA, despite optimum medical management. At all material times, no widely accepted medical group specializing in cardiology in the United States has ever recommended, advised, or suggested that closure is appropriate for stroke or migraine prevention to patients that have not had recurrent crypotogenic strokes.

15. In 2011, Defendant IHC adopted internal Guidelines for Percutaneous Closure of Septal Defects of the Atrium that mirrored those promulgated by the American Heart Association/American Stroke Association (AHA/ASA). The Guidelines state that "PFO closure may be considered for patients with recurrent cryptogenic stroke (CS) despite optimal medical therapy." The IHC Guidelines note that PFO closure is only appropriate for "recurrent, confirmed, clinical cryptogenic TIA or stroke."

16. PFO could also, under Defendant IHC's Guidelines, be considered for "patients with a single well-documented significant stroke or systemic emboli in a high-risk patient who has been comprehensively evaluated for alternative cause of embolic stroke." Under either circumstance, the Guidelines require that the cardiologists ensure that the diagnosis of PFO and cryptogenic stroke or embolism is confirmed by an independent neurology consult or a brain CT or MRI, a MRA of the head and neck, an ambulatory telemetry monitor for atrial fibrillation, and a TTE with bubbles to confirm the diagnosis. Defendant IHC's Guidelines make clear that PFO closure is never indicated for migraine headaches.

17. Defendant IHC's Guidelines are clear that PFO closure for migraine can only be performed in the clinical trial setting and that there is currently "no RCT [randomized clinical trials] to support use of PFO closure in the treatment of migraine headaches or asymptomatic white-matter lesions." These latter two categories of symptoms are precisely what Defendant Sorensen treated Plaintiff for with a PFO closure.

18. Defendant Sorensen frequently touted his excessive volume, touting that he has more than a "10 year/3000 device history" of utilizing various devices (*i.e.* Amplatzer and Gore) to perform PFO and ASD closures. Defendant Sorensen often referred patients to his "research" and "data" for PFO and ASD closures at www.sorensenmd.com.

## GENERAL ALLEGATIONS

19. The following general allegations are common to all claims alleged herein:

20. As noted, Defendant Dr. Sorensen is a cardiologist and was practicing interventional cardiology. He had privileges at Defendant IHC and at other hospitals. From roughly 2002 to 2012, Defendant Sorensen performed more than 4,000 PFO and ASD closures, the majority of those at IHC. The administration at IHC was on notice because of the sheer volume

of the procedures performed by Defendant Sorensen and because of complaints from other practitioners and employees that Defendant Sorensen was engaged in a practice of regularly performing unnecessary, invasive cardiac procedures on his patients. Defendants enriched themselves by submitting false and fraudulent medical billing to insurance companies, including Plaintiff's, for medically unnecessary procedures.

21. During the hiring and credentialing process at IHC, Sorensen advised IHC representatives of the medical treatment he was qualified to perform, and specifically informed IHC how he would perform PFO closures. These procedures would include performing PFO and ASD closures on patients that did not have recurrent cryptogenic strokes. Despite this, Defendant IHC gave Sorensen hospital privileges, hired and paid him, and allowed him to utilize their catheterization laboratory to perform these PFO procedures.

22. Sorensen's cardiac privileges at IHC were suspended on or about June 27, 2011, following an internal investigation concluded that Sorensen had performed multiple, medically unnecessary PFO closures and that Sorensen represented a threat to the health and safety of the patients treated at IHC.

23. The letter from IHC to Defendant Sorensen informing him in writing of his suspension (effective June 27, 2011 through July 11, 2011), stated that the suspension was "taken in good faith to prevent a threat to the health or safety of patients" at IHC and to "provide the Medical Executive Committee the opportunity to further evaluate the patient care you have provided, your professional conduct within the hospital and [to] determine if additional action regarding your membership and privileges should be taken beyond the 14 day suspension."

24. Dr. Sorensen's suspension was the direct result of the IHC's acknowledgement of what it had known for years, that Sorensen had performed thousands of medically unnecessary

PFO closures at IHC. The suspension was a reversal of sorts for IHC because it had long encouraged, profited, and provided a haven for Defendant Sorensen's practice.

25. Further, Defendant Sorensen and IHC created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures. These statements include documenting migraine or stroke history where none existed, such as Plaintiff's case.

26. Defendant IHC supplied Sorensen with its catheterization lab facilities, hospital staff such as nurses, administrative, and other support staff, and privileges to perform these procedures whenever he saw fit, including for Plaintiff Lisa Tapp's PFO procedure in October 2008. For example, the Patient Information pamphlet passed on to Plaintiff (and many other patients) touts "a dedicated, specialized team of echo, nursing, catheterization laboratory, and physician members" as "Why Our Program May Be Right For You" (Slide 30).

27. Sorensen would routinely mislead his patients, who had no previous strokes or TIAs, into believing that they were at extreme risk of debilitating stroke because of their PFO or ASD. He would further mislead them that a closure procedure would be effective and was medically necessary in order to prevent strokes. These misrepresentations were made to the vast majority of his patients, including Plaintiff.

28. Despite his representations to his patients, Sorensen often created medical charts that falsely reflected that the patients had suffered from, or were at risk of suffering from, recurrent cryptogenic stroke in order to get insurance to pay for the procedure. The effort to disguise the true diagnosis and reason for the closures shows that Sorensen was always aware of and understood the true standard of care for these procedures. IHC knew or should have known through a cursory review of the patients' files that they did not meet the closure indications in the standard of care.

IHC, SCG, and Sorensen engaged in a conspiracy and/or concert of action, with each other to profit from the perpetuation of Sorensen's medically unnecessary closures.

29. In a report released to the entire Department of Cardiology at IHC, it reported that the study showed that "compliance with the guidelines for performing PFO closures" at IHC was "less than ideal." The review showed that the Guidelines had been violated in many of the cases reviewed.

30. Even though it did not issue these Guidelines until 2011, at all times relevant to this case, IHC knew that septal closures were rarely indicated. For years IHC ignored the loud objections from its own medical staff and leadership, including the Director of the Catheterization Laboratory, Dr. Revenaugh, and the Medical Director for Cardiovascular Services at Intermountain Healthcare, Dr. Donald L. Lappe, as well as written warnings and complaints from Professor Andrew Michaels of the University of Utah. Further, IHC was informed by Dr. Nancy Futrell, a neurologist who was a co-investigator with Defendant Sorensen on a trial performed at IHC for the closure devices used by Defendant Sorensen, that Defendant Sorensen was performing unnecessary closures outside of the criteria set by the trials. She spoke with several individuals associated with IHC regarding Dr. Sorensen, including Dr. Lappe, chief of cardiology; William Hamilton, medical director; Jeffrey Anderson, associate chief of cardiology; and Liz Hammond.

31. After Sorensen's 14-day suspension, he returned to work at IHC on or about July 12, 2011. It immediately became apparent that Sorensen had no intention of complying with the IHC Guidelines for PFO closures, and that he would continue to perform medically unnecessary procedures on patients not suffering from recurrent cryptogenic stroke despite optimal medical therapy. Because Sorensen refused to comply with the Guidelines and represented an immediate threat of harm to his patients, IHC moved to suspend Sorensen from practice in September 2011.

Sorensen and IHC entered a Settlement Agreement, which was designed to prevent his permanent suspension. However, within days of entering the Agreement, Sorensen was notified by IHC that he was in violation of the Agreement. IHC threatened to take immediate action to suspend him, and to report his misconduct to the National Practitioner Database. Sorensen promptly resigned to avoid these adverse consequences.

32. In Fall 2011/Winter 2012, Dr. James L. Orford, listed in the Cardiology Department at Intermountain Health Center, authored an article "Understanding the Heart Defect – Patent Foramen Ovale" in The Classroom on Intermountain's website. This publication lists "Intermountain Medical Group" with a link at the bottom.

33. Speaking on behalf of Intermountain, Dr. Orford states the following:

- "Because PFO is very common and never causes any problems in most patients, undergoing surgery to possibly prevent migraines and/or stroke usually isn't worth the risk."
- "It has been noted that PFO is more common in patients who experience migraine with aura, but may patients with a PFO do not have migraine headaches and many migraine patients do not have a PFO."
- "Furthermore, there is no conclusive evidence that fixing a PFO will benefit migraines."
- "In a few cases, where patients have already suffered a confirmed cryptogenic stroke without any possible cause, closing a PFO may be a viable option to prevent future strokes."
- "However, it is important to consult with a neurologist and a cardiologist to determine all of your options and whether surgical closure is recommended."

- "Patients are also encouraged to enroll in a clinical trial so their response to treatments can be studied, allowing scientists to learn more about this condition."
- "As leaders in cardiology, Intermountain Healthcare is always very conscientious regarding how new technology is applied. For this reason, the Intermountain Medical Group instituted specific "Guidelines for Percutaneous Closure of Septal Defects" throughout all our hospitals and clinics."
- "We believe it is important to have clear, positive evidence for both the short-term and long-term consequences of any procedure."

Despite this publication and clear recognition, IHC did nothing to alert patients, including Lisa Tapp, that no "clear, positive" evidence existed that PFO closure was effective for stroke prevention in absence of a history of cryptogenic strokes or for migraine headache prevention.

34. Defendant IHC also published "Fact Sheet for Patients and Families – PFO and ASD Closure in the Cath Lab" with a publication range of 2011-2016. Among the recognized risks of a PFO or ASD Closure include: temporary leg numbness or weakness in the first few hours, bruising, bleeding, infection, or blood vessel damage whether cathether(s) were inserted, damage to the heart muscle that may require open heart surgery, abnormal heart rhythm, blood clots, heart attack or stroke, negative reaction to anesthetic or dye, and unforeseen complications. While these risks are "uncommon" they are present for PFO and ASD Closures. The Fact Sheet for Patients and Families also states the following:

- **"Why Might I need a PFO or ASD Closure?** You might need a PFO closure if you've had a stroke that is related to PFO."

- "What are the benefits of a PFO or ASD closure procedure? PFO Closure has not been found to reliably reduce migraines. Also, it is not indicated unless you've had a previous TIA or stroke."

35. Despite the results of this audit, patient literature representations, stated opinion of IHC cardiologists, and ample evidence that Defendant Sorensen had performed thousands of PFO closures, Defendant IHC deliberately and consciously chose not to expand its audit to other PFO closure patients from past years, including Plaintiff Lisa Tapp  Defendant IHC never released information to the public that Sorensen had performed medically unnecessary PFO procedures, as this information was kept internal.

36. IHC made a deliberate and conscious decision not to inform patients that they may have had a medically unnecessary surgery, and chose not to reimburse Plaintiff Lisa Tapp, her insurance company, (or any patients) who had procedures performed unnecessarily. Instead, IHC kept the profits for itself.

## PLAINTIFF LISA TAPP'S PFO CLOSURE AND INJURIES

37. Plaintiff Lisa Tapp was 43 years old when she underwent the percutaneous closure of a patent foramen oval at Intermountain Medical Center in Salt Lake County on September 18, 2008. The procedure was performed by Defendant Sherman Sorensen, M.D. using an 18 millimeter Amplatzer septal occlude device—a device not approved by the FDA for use in this manner. The safety and efficacy for using the Amplatzer device in a PFO closure to prevent strokes on patients without recurrent cryptogenic stroke has never been established, even to this day.

38. In fact, at all material times the Amplatzer septal occcluder has been indicated for patients with "echocardiographic evidence of ostium secundum atrial septal defect." The

Amplatzer instructions for use unequivocally state, "The use of this device has not been studied in patients with patent foreman ovale."

39. Prior to Lisa's percutaneous closure, she underwent a neurological history and physical by Walter Reichert M.D. on August 15, 2008. The patient described a two-month history of continuous paresthesias in the back of the neck and head. She also described "mild numbness in her right thumb and hand while she is seated." Importantly, a detailed neurological exam did not show any abnormalities; specifically, there were no motor/strength deficits and no sensory deficits.

40. On August 20, 2008, a brain MRI, MRA of the intracranial arteries and an MRI of the cervical spine were performed at Western Neurological Associates, where Dr. Reichert practiced. The brain MRI was interpreted to show about fifteen bilateral non-specific white matter lesions. A differential diagnosis is given for this finding: "includes demyelinating disease, migraine headaches, vasculitis/inflammatory disease, chronic microvascular ischemic disease, hypertension and post-traumatic sequela." The differential diagnosis did not include embolic strokes or events.

41. On September 2, 2008, Lisa received a transthoracic echocardiogram and transcranial doppler study in Defendant Sorensen's office, SCG. The transthoracic echo is interpreted to show an abnormal bubble study consistent with a right to left shunt across the atrial septum and the transcranial doppler study is interpreted to show 5/5 conductance with a valsalva maneuver. The 5/5 conductance is used to place the patient at "high risk stratification for stroke."

42. On this same day, Defendant Sorensen performed a history and physical on Lisa. Among Defendant Sorensen's findings, he concluded that Lisa did not have hyper coagulability (despite a lack of testing for this), that she developed "well-defined symptoms of hemisensory"

(despite no evidence of this in Lisa's neurological exam), and that she had a history of migraines (despite Lisa's own claims to the contrary). Defendant Sorensen went on to state that Lisa had "a change in her level of consciousness" and that her "right-sided weakness has been persistent." None of these findings were reflected in Lisa's neurological exam. Defendant Sorensen claims the non-specific white matter lesions seen on Lisa's brain MRI "are, therefore, most likely embolic." Defendant Sorensen made this diagnosis with virtually no medical support.

43. To persuade Plaintiff to undergo a PFO closure, Defendant Sorensen represented to Plaintiff that she was at high risk of a debilitating stroke due to the presence of her PFO/ASD. In truth, the mere presence of the defect, without more, including a history of cryptogenic stroke, is not a significant risk factor for stroke. Further, Sorensen passed out a Patient Information Patent Foreman Ovale (PFO) handout to Plaintiff. Sorensen's patient literature contained fraudulent misrepresentations, unsupported data and statistics, outright falsehoods, and other misleading statements, such as the following:

- "Until recently, 40% of all strokes were unknown cause. We now know that most of these unexplained strokes may be caused by a PFO (Patent Foramen Ovale)" (Stroke and PFO Slide 2).
- "Strokes resulting from septal defects have a 50% mortality rate."
- "PFO is diagnosed in 50-70% of patients with stroke of unknown cause" (What is Known About PFO and Stroke Slide 12).
- "Continued lifelong risk of stroke ranging from 2-9% each year." (PFO Treatment Options Aspirin/Plavix/Coumadin Slide 17).
- "Stroke reduction to less than 1%" (PFO Treatment Options Catheter Closure of PFO).
- "Septal Defect Closure Safety and Efficacy" (Slide 28).

- "Our rigorous Program requirements assure that you are informed and receive the safest and most effective treatment" (Why Our Program Might Be Right For You Slide 30).

These statements induced and persuaded Plaintiff to undergo a PFO closure at IHC by inducing fear of an imminent and debilitating stroke, downplaying safer and accepted treatment options, misrepresenting the indication for PFO in the medical community, and downplaying the risks of PFO closure.

44. Further, Plaintiff's medical records authorized by Defendant Sorensen are replete with fraudulent misrepresentations, falsehoods, and other misleading statements containing information presented to Plaintiff to induce her to have the closure procedure. These statements include:

- "Our approach is a preventative strategy. It is scientifically based, but it is an aggressive strategy." In fact, Dr. Sorenson's method has never been accepted in any scientific journal, organization, been approved for a randomized clinical trial, and/or the peer review process for his data and proposed indication for PFO closure. "We, therefore follow a preventative strategy and risk stratify patients based on the studies…proposed by the American Academy of Neurology." That is false; the AAN did not recommend closure outside of clinical trials and encouraged patients to participate in research protocols.
- "8 studies demonstrate that very high flow is the main feature of stroke risk." In fact, the AAN Practice Parameter did not find an association, much less causation, of shunting and risk of stroke recurrence.

- "Randomized trials are not available currently." In reality, the Closure I trial was opened in Salt Lake City, Utah. It was halted due to Defendant Sorensen's medically unnecessary off-label PFO procedures of patients outside the trial.
- "Coumadin is considered to be unsafe and ineffective…based on studies." In fact, the SPIRIT, WASID and WARRS studies showed no such thing.
- Within Plaintiff's medical records, Sorenson noted that Ms. Tapp had a history of migraine. That too was false, misleading, and inaccurate. Dr. Sorenson made this notation without any objective evidence.
- Defendant Sorenson certified that his echocardiography lab was certified by ICAEL (Intersocietal Commission for Accreditation Laboratories) using the ICAEL logo on his echochardiogram. In fact, his lab was never accredited by ICAEL and this was false.

Plaintiff was unaware of the misrepresentations and falsehoods in her medical records and instead trusted what the Defendants had told her during her of treatment. Further, and even if she had been aware of some the factual mischaracterizations, as non-expert she could not have understood their implications as it relates the appropriateness of her medical treatment.

45. Ultimately, Defendant Sorensen performed the percutaneous closure on September 18, 2008, at Defendant IHC's Cardiac Catheterization Laboratory. The following day, a transthoracic echocardiogram was performed at Defendant IHC on Lisa prior to discharge. A color-flow doppler test was not performed to evaluate the atrial septum for a residual shunt, which was ostensibly one of the reasons for closing Lisa's PFO.

46. In a patient with strong or definitive evidence for embolic stroke, the standard of care requires a comprehensive evaluation for all of the causes of embolic stroke. This was not

performed by Dr. Sorensen in his care of Plaintiff. A comprehensive evaluation for causes of "cryptogenic" stroke includes an MRI of the brain (which was done in this case), imaging of the extra cranial and intracranial cerebral arteries, 3-4 week rhythm monitoring to look for paroxysmal atrial fibrillation, imaging of the aorta to look for atherosclerotic disease, lower extremity venous doppler/ultrasound, MRV of the abdominal and pelvic veins, and a hyper coagulability workup. Sorensen did not conduct this evaluation on Plaintiff.

47. Defendant IHC was aware that this type of off-label medically unnecessary PFO closure was being performed on hundreds of patients, including Plaintiff, during this time of October 2008 as Defendant Sorensen had informed Defendant IHC he would perform the procedure in this manner.

48. On October 15, 2008, Lisa Tapp was seen by Defendant Sorensen for a follow-up visit. Lisa complained of palpitations and a rapid heart rate. Defendant Sorensen did not screen Lisa for atrial fibrillation, which carries with it the risk of stroke.

49. Because of Defendants' conduct, Lisa suffered damages, including undergoing an unnecessary surgical procedure and hospital stay, as well as medical expenses, physical pain, and emotional anguish.

50. Despite IHC's awareness of Sorensen's fraudulent and/or negligent practices, it did nothing to notify Plaintiff. Instead, IHC actively allowed Sorensen's practice to continue in order to profit from the thousands of unnecessary procedures performed on patients like Plaintiff. In fact, IHC has to this day actively concealed its knowledge about Sorensen's rogue and fraudulent practices at its facility from patients, third party payers, and the public, and has retained the money earned off of Sorensen's medically unnecessary surgeries.

51. The FDA issued a warning about serious erosion events with Amplatzer Septal Occluder devices in October 2013. Although erosion events are not currently an issue for Lisa Tapp, the Amplatzer Septal Occluder device is permanently implanted and carries this risk.

52. IHC sent a letter to patients around February 2014 alerting patients who had an Amplatzer Septal Occluder device implanted about the FDA's findings with a link to the FDA announcement and St. Jude patient advisory. The letter sent to patients did not mention anything about Dr. Sorensen, the PFO closure procedure itself, or that medical malpractice may have occurred. Nor did the letter inform patients, including Lisa Tapp, that the PFO closure was medically unnecessary to begin with, that the use of this device for PFO closure had not been studied, accepted, and/or approved in the medical community, and that Defendant Sorensen had asserted misrepresentations, falsehoods, half-truths, and engaged in other deceptive acts.

**FIRST CLAIM FOR RELIEF: NEGLIGENCE (HEALTH CARE MALPRACTICE)**

53. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

54. Defendants, individually, collectively, and through the acts and omissions of their agents, servants, employees, physicians, nurses, therapists, and technologists (hereinafter collectively "Defendants") accepted Plaintiff as a patient, and thereby assumed various duties of care.

55. At all relevant times, Defendants held themselves out as being able to provide full care and treatment for patients requiring medical care of the type that Plaintiff required, including, but not limited to, paresthesias in the back of the neck and head and non-specific white matter lesions, among other things.

56. The degree of care and treatment provided to Plaintiff fell below the acceptable standards of care for the types of medical care and treatment required by Plaintiff and provided by Defendants.

57. Specifically, Defendants breached the applicable standards of care in multiple ways including, but not limited to:

a. Falsifying Plaintiff's medical records to indicate that Plaintiff was an appropriate candidate for closure;
b. Misleading Plaintiff regarding the risks and benefits associated with closure and regarding the necessity of treatment;
c. Failing to obtain an adequate history which resulted in an improper medical diagnosis that Plaintiff was an appropriate candidate for closure;
d. Failing to conduct an adequate physical and to obtain appropriate diagnostic testing, which resulted in an improper medical diagnosis that Plaintiff was an appropriate candidate for PFO closure; Performing a medically unnecessary medical procedure with a device that was not FDA approved for this use;
e. Failing to test for residual shunting after performing the PFO closure; and
f. Failing to screen Plaintiff for atrial fibrillation when she presented with palpitations and a rapid heart rate.

58. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Defendants caused Plaintiff to undergo unnecessary medical procedures, testing, and follow-up visits, incur unnecessary medical expenses, and experience physical injuries and emotional anguish.

59. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Plaintiff has suffered personal injuries, including by not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

60. Plaintiff has therefore been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SECOND CLAIM FOR RELIEF: NEGLIGENCE**

61. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

62. At all relevant times, Defendants owed Plaintiff various duties of care, including but not limited to common law and statutory duties.

63. Defendants, individually and collectively, breached these duties of care.

64. As a sole, proximate, and foreseeable result of Defendants' acts and omission, Defendants caused personal and other injuries to Plaintiff.

65. Plaintiff has been injured and is entitled to recover general and special damages in amounts to be determined at trial.

**THIRD CLAIM FOR RELIEF: NEGLIGENT MISREPRESENTATION**

66. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

67. Defendants, individually and collectively, represented to Plaintiff that medical procedures, testing, and follow-up visits were medically necessary.

68. Defendants' representations that Plaintiff's medical procedures, testing, and follow-up visits were medically necessary was, in fact, not true.

69. Defendants failed to use reasonable care to determine whether the representations regarding the necessity of Plaintiff's medical care was true.

70. Defendants were in a better position than Plaintiff to know the true facts regarding Plaintiff's medical procedures, testing, and follow-up care.

71. Defendants had a financial interest in performing medically unnecessary procedures, testing, and follow-up care on Plaintiff.

72. Plaintiff relied on Defendants' representations, and it was reasonable for her to do so.

73. Plaintiff has therefore been injured as a result of relying on Defendants' representations and is entitled to recover general and special damages in an amount to be determined at trial.

**FOURTH CLAIM FOR RELIEF: NEGLIGENT CREDENTIALING**

74. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

75. Defendant IHC owes a duty to patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges to them. It also has the duty to periodically monitor and review the qualifications and competency of its medical staff.

76. Defendant IHC breached its duty to exercise reasonable care in its selection of its medical staff, and in granting specialized privileges to and periodically monitoring and reviewing the qualifications and competency of its medical staff.

77. As a sole, proximate, and foreseeable result of its breach, Defendant IHC caused harm to Plaintiff.

78. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**FIFTH CLAIM FOR RELIEF: FRAUDULANT NON-DISCLOSURE/CONCEALMENT**

79. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

80. Defendants owed a duty to Plaintiff to disclose important facts, such as the medical necessity of Plaintiff's medical care, to Plaintiff.

81. Defendants knew that the medical care Defendants provided to Plaintiff was not medically necessary, and failed to disclose this to Plaintiff.

82. Plaintiff did not know that the medical care provided by Defendants was not medically necessary.

83. Defendants' failure to disclose the fact that Plaintiff's medical care was not necessary was a substantial factor in causing Plaintiff's damages. Had Plaintiff known that her closure surgery was not necessary, Plaintiff would not have undergone the surgery.

84. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SIXTH CLAIM FOR RELIEF: FRAUD**

85. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

86. At all relevant times, Defendants had a duty and obligation to disclose to Plaintiff true facts concerning the medical care provided to Plaintiff by Defendants.

87. Defendants intentionally concealed material facts concerning Plaintiff's medical care from Plaintiff including, but not limited to the following:

a. Falsifying Plaintiff's medical records to indicate that she was an appropriate candidate for closure;

b. Performing medically unnecessary medical procedures with a device that was not FDA approved for this use; and

c. Concealing from Plaintiff that medical procedures, testing, and follow-up care was unnecessary.

88. Defendants made false statements and misrepresentations about important facts regarding Plaintiff's medical care.

89. Defendants made these false statements and misrepresentations described above knowing that the statements were false, or with reckless disregard for their truth.

90. Defendants made the false statements and misrepresentations to Plaintiff, with the intent that Plaintiff would rely on the statements.

91. Plaintiff did reasonably rely on the false statements and misrepresentations made by Defendants.

92. As a sole, proximate, and foreseeable result of Defendants' false statements and misrepresentations, Plaintiff has suffered personal injuries, including but not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

**SEVENTH CLAIM FOR RELIEF: CIVIL CONSPIRACY**

93. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

94. Defendants were acting in a conspiracy to commit fraud, thereby increasing their profits through the performance of medically unnecessary procedures on patients, including Plaintiff.

95. There was an agreement and meeting of the minds among Defendant Sorensen, Defendant SCG, and Defendant IHC to misrepresent the need for and induce patients, including Plaintiff, into undergoing medically unnecessary procedures, testing, and follow-up. Defendants agreed to act in concert in making these misrepresentations about the necessity of medical procedures to Plaintiff.

96. There were multiple unlawful, overt acts by Defendant Sorensen, Defendant SCG, and Defendant IHC in furtherance of their scheme, including without limitation, Defendants' fraud.

97. As a result of this conspiracy, Defendant Sorensen, Defendant SCG, and Defendant IHC, should be held jointly and severally liable for the conduct of the other co-conspirators and the damages that Plaintiff sustained as a proximate result thereof, including without limitation personal injuries and other injuries.

98. Plaintiff would further show that Defendant Sorensen and Defendant SCG were operating as alter egos for the purpose of perpetrating the above described conspiracy. There was such a unity of interest and ownership that the separate personalities of the company and the individual did not exist. Observing the corporate form will sanction this conspiracy, promote injustice, and allow an inequitable result.

## EQUITABLE TOLLING/FRAUDULENT CONCEALMENT

99. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

100. Because of Defendants' concealment of material facts and misleading conduct, Plaintiff was not aware of her causes of action.

101. Plaintiff found out about her cause of action only after learning of Defendants' conduct through lawyer advertising in 2017.

102. Defendants took affirmative steps to conceal Plaintiff's cause of action. Given Defendants' concealment and misleading conduct, a reasonable plaintiff would not have discovered the cause of action earlier.

103. IHC, through its employees, physicians, internal audit, and Sorensen's own representations was well aware that Sorensen had performed medically unnecessary PFO and ASD closures on patients such as Plaintiff, but chose not to conduct a more expansive audit and/or inform patients that had an unnecessary surgery.

104. Neither Sorenson, nor IHC ever notified Plaintiff that she had received an unnecessary procedure, that she was never indicated for the surgery to begin with, that the device implanted into Plaintiff was never medically necessary, was retained in her body for no medical purpose, and that the informed consent contained fraudulent, misleading, and/or incomplete statements. Neither Sorenson, nor IHC, ever compensated Plaintiff for the unnecessary medical surgery she underwent by reimbursing the costs of the procedure.

105. Neither Sorensen, nor IHC, ever made a public statement, sent a letter, made a public announcement, or issued a press release to inform patients, such as Plaintiff Lisa Tapp, may have had a medically unnecessary PFO closure at IHC at any time.

106. Defendants' misrepresentations and misleading conduct constitutes fraudulent concealment that equitably tolls any proffered statute of limitation that may otherwise bar the recovery sought by Plaintiff.

107. Plaintiff did not know, nor should have known, of the causes of action against Defendants prior to being put on notice of Defendants' potential liability in 2017. She neither discovered, nor reasonably should have discovered, the facts underlying her causes of action before any proffered statute of limitations period expired.

108. As a result of Defendants' concealment of the true character, quality and nature of their conduct, they are estopped from relying on any statute of limitations defense. Defendants' affirmative acts and omissions, before, during, and/or after their actions causing Plaintiff's injury prevented Plaintiff from discovering the injury or cause thereof until recently in 2017. Such conduct tolls the limitations pursuant to the Utah Health Care Malpractice Act 78B-3-404(b).

109. Defendants' conduct, because it was purposely committed, was known or should have been known by them to be dangerous, heedless, reckless, and without regard to the consequences or the rights and safety of Plaintiff.

## PRAYER FOR RELIEF

**WHEREFORE**, Plaintiff prays for a judgment (under URCP: Tier 3) against Defendants in an amount to be determined by the trier of fact for the following damages:

a. For special damages in an amount to be determined at trial;

b. For general damages in an amount to be determined at trial;

c. For pre and post judgment interest on all special damages pursuant to Utah law;

d. For costs and attorney fees to the extent allowed by law; and

e. For such other relief as the Court deems appropriate.

RESPECTFULLY SUBMITTED this 21st day of November 2017.

/s/ Rhome D. Zabriskie
**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

**FLEMING, NOLEN & JEZ, LLP**
Rand P. Nolen (Pro Hac Vice submission in progress)
David L. Hobbs (Pro Hac Vice submission in progress)
2800 Post Oak Blvd., Suite 4000
Houston, TX 77056-6109
Telephone: (713) 621-7944
Facsimile: (713) 621-9638
Email: rand_nolen@fleming-law.com
Email: david_hobbs@fleming-law.com

*Counsel for Plaintiff*

CERTIFICATE OF SERVICE

I hereby certify that that a true and exact copy of the foregoing has been served on the following via the Court's ECF filing system and/or Email on 21ST day of November, 2017:

Alan C. Bradshaw
Sammi V. Anderson
John (Jack) T. Nelson
Mitch M. Longson
Manning, Curtis, Bradshaw & Bednar PLLC
136 East South Temple, Suite 1300
Salt Lake City, UT 84111
Phone: 801-363-5678
Fax: 801-364-5678
abradshaw@mc2b.com
sanderson@mc2b.com
jnelson@mc2b.com
mlongson@mc2b.com

*Attorneys for IHC Health Services, Inc.*

Michael J. Miller
Strong & Hanni
102 South 200 East, Suite 800
Salt Lake City, UT 84111
mmiller@strongandhanni.com

*Attorney for Defendants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

/s/ Rhome D. Zabriskie
**Rhome D. Zabriskie**

# Addendum E

**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

*Counsel for Plaintiff*

**IN THE THIRD JUDICIAL DISTRICT COURT – SALT LAKE CITY**

**SALT LAKE COUNTY, STATE OF UTAH**

| | |
|---|---|
| **PIA MERLO-SCHMUCKER,**<br><br>Plaintiff,<br><br>v.<br><br>**SHERMAN SORENSEN, M.D.; SORENSEN CARDIOVASCULAR GROUP; AND ST. MARK'S HOSPITAL**,<br><br>Defendants. | **FIRST AMENDED COMPLAINT**<br>**(Tier 3 Filing)**<br><br>**(Jury Demanded)**<br><br>**Civil No. 170906130**<br><br>**Judge Matthew Bates** |

**COMES NOW** Plaintiff, by and through counsel, and hereby complain for causes of action against the above-captioned Defendants, alleging as follows:

## PARTIES, JURISDICTION, AND VENUE

1. Plaintiff Pia Merlo-Schmucker is, and at all relevant times has been, a resident of Davis County, State of Utah.

2. Defendant SHERMAN SORENSEN, M.D. was, at all relevant times, a licensed physician providing health care services in Salt Lake County, State of Utah.

3. Defendant SORENSEN CARDIOVASCULAR GROUP (SCG), was at all material times, a Utah professional corporation in the business of providing health care services to residents of Utah. Defendant SCG's principal place of business is located at 5169 Cottonwood Street, No. 610, Murray, Utah. Defendant Sherman Sorensen owned and operated SCG as his primary medical practice.

4. Defendant ST. MARK'S HOSPITAL. (St. Mark's) is a for-profit corporation based in Salt Lake City, Utah with its principal place of business and corporate office at 1200 E 3900 S Salt Lake City, UT 84124. St. Mark's Registered Agent for Service CT Corporation System, 1108 E South Union Ave., Midvale UT 84047.

5. Upon information and belief, at all material times, each of the Defendants were, or may have been, an agent, servant, employer, employee, joint venture, partner, and/or alter ego of one or more of each of the remaining Defendants, and were at all times acting within the purpose and scope of such agency, servitude, joint venture, alter ego, partnership, or employment, and with the authority, consent, approval, and/or ratification of each remaining Defendant.

6. At all material times, Defendants were health care providers within the meaning of the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-401 et seq., and each Defendant provided health care services to Pia Merlo-Schmucker.

7. This Court has jurisdiction over this action pursuant to Utah Code Ann. § 78A-5-102.

8. Venue is proper in this Court pursuant to Utah Code Ann. § 78B-3-307.

9. In bringing this action, Plaintiff complied with all statutory requirements regarding pre-litigation review of this matter as set forth in the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-416.

## BACKGROUND

10. This case is one of more than a thousand cases that are presently working their way through the prelitigation process, which involve the medically unnecessary heart surgery by Dr. Sherman Sorensen related to two kinds of holes in the heart. One is called an atrial septal defect (ASD), and the other is a patent foramen ovale (PFO). Both are holes in the wall of tissue (septum) between the left and right upper chambers of the heart (atria). An ASD is considered a birth defect and is a failure of the septal tissue to form between the atria, PFOs can only occur after birth when the foramen ovale fails to close.[1]

11. Life threatening ASD's are generally discovered at birth and corrected immediately. However, there are billions of adults who have small openings between the left and right atriums of their hearts. The foramen ovale is an opening located in the wall separating the two upper chambers of the heart, the atrial septum, which is used during fetal circulation to redirect blood through the heart. In 75% of the population, the foramen ovale closes at birth when increased blood pressure on the left side of the heart forces the opening to close. In those cases, where the foramen ovale does not close at birth, a patent foramen ovale (PFO) results.

12. Approximately 25% of the healthy population have a PFO and will never require any treatment or evaluation. Apart from extremely rare cases, patients with a PFO remain completely unaware of the presence of the PFO because it's almost never associated with symptoms. Persistent patency of the foramen ovale is considered a normal anatomic variation.

[1] Dr. Sorensen at times earlier in his career referred to these two conditions interchangeably, but for insurance reimbursement purposes decided that all PFO's were ASD's later in his practice. Either way, and no matter what he called them, he closed holes indiscriminately and without medical justification on thousands of people, including the Plaintiff.

13. Only if a patient has a recurrence of cryptogenic (originating from unexplained causes) stroke or transient ischemic attack (TIA), likely due to paradoxical embolization through a PFO, and despite optimal medical therapy, may it be appropriate to close the PFO. Generally, this closure is performed through a percutaneous surgical procedure. In the percutaneous procedure, a patient undergoes a cardiac catheterization to determine the size and location of the PFO.

14. There has long been general agreement in the medical community—as far back as 2003—that PFO closure is not medically necessary, except in the limited circumstances where there is a confirmed diagnosis of a recurrent cryptogenic stroke or TIA, despite optimum medical management. At all material times, no widely accepted medical group specializing in cardiology in the United States has ever recommended, advised, or suggested that closure is appropriate for stroke or migraine prevention to patients that have not had recurrent crypotogenic strokes.

## GENERAL ALLEGATIONS

15. The following general allegations are common to all claims alleged herein:

16. As noted, Defendant Dr. Sorensen is a cardiologist and was practicing interventional cardiology. He had privileges at Defendant St. Mark's and at other hospitals. From roughly 2002 to 2012, Defendant Sorensen performed more than 4,000 PFO and ASD closures, many of those at St. Mark's. Dr. Sorensen performed the procedures at a rate that dwarfed the rest of the country by a factor of ten-to-twenty fold, making him a true outlier.

17. The administration at St. Mark's was on notice because of the sheer volume of the procedures performed by Defendant Sorensen and because of complaints from other practitioners and employees that Defendant Sorensen was engaged in a practice of regularly performing

unnecessary, invasive cardiac procedures on his patients. St. Mark's ignored obvious warnings to halt these procedures so that it could secure and maintain a lucrative stream of income.

18. Further, during the hiring and credentialing process at St. Mark's, Sorensen advised St. Mark's representatives of how he would perform closures and under what conditions. And a result, St. Mark's was aware that he would be performing unnecessary closures on patients that did not have recurrent cryptogenic strokes.

19. Further, Sorensen's cardiac privileges at another hospital were suspended on or about June 27, 2011, following an internal investigation concluded that Sorensen had performed multiple, medically unnecessary PFO closures and that Sorensen represented a threat to the health and safety of the patients treated. And St. Mark's CEO Steve Bateman and physician liaison Nikki Gledhill were aware of Sorensen's suspension.

20. Defendants Sorensen and St. Mark's created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures. These statements include documenting migraine or stroke history where none existed. For instance, Sorensen often created medical charts that falsely reflected that the patients had suffered from, or were at risk of suffering from, recurrent cryptogenic stroke in order to get insurance to pay for the procedure. The effort to disguise the true diagnosis and reason for the closures shows that Sorensen was always aware of and understood the true standard of care for these procedures.

21. Sorensen would routinely mislead his patients, who had no previous strokes or TIAs, into believing that they were at extreme risk of debilitating stroke because of their PFO or ASD. He would further mislead them that a closure procedure would be effective and was medically necessary in order to prevent strokes. These misrepresentations were made to the vast majority of his patients, including Plaintiff.

22. Despite the fact that St. Mark's knew that Sorensen was performing medically unnecessary closures, and knew that Sorensen had been suspended for performing medically unnecessary closures at another hospital, St. Mark's Hospital continued to court Sorensen's business, provide a platform and assistance to Sorensen, and advertise and promote Sorensen and closure practice to the public for its own financial gain.

23. In particular, the catheterization lab staff at St. Mark's became financially dependent on Sorensen's incredible volume. The majority of patients at St. Mark's cardiac catheterization laboratory came from Sorensen, dwarfing all other cardiology business at St. Mark's. As a result, St. Mark's provided special treatment to Sorensen with staffing and scheduling in its catheterization lab, often to the detriment of true cardiac patients and other cardiologists. St. Mark's also provided open access for PFO industry representatives to the lab and personnel. Industry provided order-in meals were available to those catheterization lab personnel that were willing to share in the largesse.

24. Ultimately, St. Mark's made a deliberate and conscious decision not to inform patients that they may have had a medically unnecessary surgery, and chose not to reimburse Plaintiff, her insurance company, or any of its other patients who had procedures performed unnecessarily. Instead, St. Mark's kept the profits for itself.

**PLAINTIFF'S CLOSURE AND INJURIES**

25. On December 21, 2010, a transthoracic echocardiogram (TTE) was performed on Ms. Merlo-Schmucker in Dr. Sorensen's office. Medical records indicate that the patient was referred by Tyler Williams MD and that the indication is cognitive changes and a murmur. A transcranial doppler study (TCD) is performed as well. The echocardiogram was interpreted to

show "severe right to left shunt after valsalva." The TCD study was interpreted to show 5+/5 conductance with calibrated respiratory strain."

26. On December 28, 2010, a brain MRI was performed at Western Neurological Associates. This did not conclusively demonstrate evidence of a previous stroke. A "tiny nonspecific focus of flair sequence hyperintensity" is described. A differential diagnosis is given that includes "embolic disease." But the radiologist also dictates "imaging artifact is not entirely excluded."

27. On February 10, 2011, a percutaneous closure of a septal defect was accomplished using a 25 mm Gore HELEX ASD device. This was guided by intracardiac echo. Dr. Sorensen referred to the septal defect as an atrial septal defect. Following deployment of the device, color flow doppler showed no left to right flow and a contrast bubble study was negative for right to left shunting.

28. On February 11, 2011, prior to discharge from St. Mark's, a transthoracic echocardiogram was performed. The report states that color flow doppler "does not demonstrate a residual shunt," but a bubble study was not performed.

29. The accepted indications for closure of an atrial septal defect include right ventricular chamber enlargement, which was not seen on Ms. Merlo-Schmucker's echocardiograms, orthodeoxia-platypnea, which was not described by Dr. Sorensen, and paradoxical embolism.

30. In a patient with strong or definitive evidence for embolic stroke, the standard of care requires a comprehensive evaluation for all of the causes of embolic stroke. This was not performed by Dr. Sorensen in his care of Ms. Merlo-Schmucker. A comprehensive evaluation for causes of "cryptogenic" stroke includes an MRI of the brain (which was done in this case), imaging

of the extra cranial and intracranial cerebral arteries, 3-4 week rhythm monitoring to look for paroxysmal atrial fibrillation, imaging of the aorta to look for atherosclerotic disease, lower extremity venous doppler/ultrasound, MRV of the abdominal and pelvic veins, and a hyper coagulability workup. But Sorensen did not perform the required comprehensive evaluation.

31. To persuade Plaintiff to undergo closure, Defendant Sorensen represented to Plaintiff that she was at high risk of a debilitating stroke due to the presence of her PFO/ASD and that closure was medically necessary. In truth, the mere presence of the defect, without more, including a history of cryptogenic stroke, is not a significant risk factor for stroke. Further, Sorensen passed out a Patient Information Patent Foreman Ovale (PFO) handout to Plaintiff. Sorensen's patient literature contained fraudulent misrepresentations, unsupported data and statistics, outright falsehoods, and other misleading statements, such as the following:

- "Until recently, 40% of all strokes were unknown cause. We now know that most of these unexplained strokes may be caused by a PFO (Patent Foramen Ovale)"
- "Strokes resulting from septal defects have a 50% mortality rate."
- "PFO is diagnosed in 50-70% of patients with stroke of unknown cause"
- "Continued lifelong risk of stroke ranging from 2-9% each year."
- "Stroke reduction to less than 1%"
- "Septal Defect Closure Safety and Efficacy"
- "Our rigorous Program requirements assure that you are informed and receive the safest and most effective treatment"

In addition, to the handout Sorensen made other misrepresentations to Plaintiff both in orally and in writing. These misrepresentations include:

- "Our approach is a preventative strategy. It is scientifically based, but it is an aggressive strategy." In fact, Dr. Sorenson's method has never been accepted in any scientific journal, organization, been approved for a randomized clinical trial, and/or the peer review process for his data and proposed indication for PFO closure. "We, therefore follow a preventative strategy and risk stratify patients based on the studies…proposed by the American Academy of Neurology." That is false; the AAN did not recommend closure outside of clinical trials and encouraged patients to participate in research protocols.
- "8 studies demonstrate that very high flow is the main feature of stroke risk." In fact, the AAN Practice Parameter did not find an association, much less causation, of shunting and risk of stroke recurrence.
- "Randomized trials are not available currently." In reality, the Closure I trial was opened in Salt Lake City, Utah. It was halted due to Defendant Sorensen's medically unnecessary off-label PFO procedures of patients outside the trial.
- "Coumadin is considered to be unsafe and ineffective…based on studies." In fact, the SPIRIT, WASID and WARRS studies referenced by Sorensen showed no such thing.
- Defendant Sorenson certified that his echocardiography lab was certified by ICAEL (Intersocietal Commission for Accreditation Laboratories) using the ICAEL logo on his echochardiogram. In fact, his lab was never accredited by ICAEL and this was false.

These false statements were intended to and did in fact induce Plaintiff to undergo closure at St. Mark's by inducing fear of an imminent and debilitating stroke, downplaying safer and accepted treatment options, misrepresenting the indication for closure, and downplaying the risks of closure.

32. Despite St. Mark's awareness of Sorensen's fraudulent and/or negligent practices, it did nothing to notify Ms. Merlo-Schmucker. Instead, St. Mark's actively allowed Sorensen's practice to continue in order to profit from the thousands of unnecessary procedures performed on patients like Ms. Merlo-Schmucker. In fact, St. Mark's has to this day actively concealed its knowledge about Sorensen's rogue and fraudulent practices at its facility from patients, third party payers, and the public, and has retained the money earned off of Sorensen's medically unnecessary surgeries.

33. Plaintiff could not have known that the information provided by Defendants was false. Instead, she trusted that Defendants Sorensen and St. Mark's, as her health care providers, were being truthful. Further, even if she had been aware of some of the factual mischaracterizations, as a non-expert she could not have understood their implications as it relates the appropriateness of her medical treatment.

34. Because of Defendants' fraudulent statements and omissions, Plaintiff was until recently unaware of her cause of action. In fact, Plaintiff only learned of the Defendants' misconduct as a result lawyer advertising. Her diligent investigation resulted in the noticing and filing of this action within the statutory period.

35. Because of Defendants' conduct, Plaintiff suffered significant damages, including:

i. undergoing an unnecessary surgical procedure and hospital stay,

ii. paying significant medical expenses to Defendants,

iii. physical pain, and

emotional anguish as a result of being told she was at immediate risk of a debilitating or even deadly stroke.

**FIRST CLAIM FOR RELIEF: NEGLIGENCE (HEALTH CARE MALPRACTICE)**

36. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

37. Defendants, individually, collectively, and through the acts and omissions of their agents, servants, employees, physicians, nurses, therapists, and technologists (hereinafter collectively "Defendants") accepted Plaintiff as a patient, and thereby assumed various duties of care.

38. At all relevant times, Defendants held themselves out as being able to provide full care and treatment for patients requiring medical care of the type that Plaintiff required.

39. The degree of care and treatment provided to Plaintiff fell below the acceptable standards of care for the types of medical care and treatment required by Plaintiff and provided by Defendants.

40. Specifically, Defendants breached the applicable standards of care in multiple ways including, but not limited to:

a. Falsifying Plaintiff's medical records to indicate that Plaintiff was an appropriate candidate for closure;
b. Misleading Plaintiff regarding the risks and benefits associated with closure and regarding the necessity of treatment;
c. Failing to obtain an adequate history which resulted in an improper medical diagnosis that Plaintiff was an appropriate candidate for closure;
d. Failing to conduct an adequate physical and to obtain appropriate diagnostic testing, which resulted in an improper medical diagnosis that Plaintiff was an appropriate

candidate for PFO closure; Performing a medically unnecessary medical procedure with a device that was not FDA approved for this use; and

41. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Defendants caused Plaintiff to undergo unnecessary medical procedures, testing, and follow-up visits, incur unnecessary medical expenses, and experience physical injuries and emotional anguish.

42. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Plaintiff has suffered personal injuries, including by not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

43. Plaintiff has therefore been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SECOND CLAIM FOR RELIEF: NEGLIGENCE**

44. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

45. At all relevant times, Defendants owed Plaintiff various duties of care, including but not limited to common law and statutory duties.

46. Defendants, individually and collectively, breached these duties of care.

47. As a sole, proximate, and foreseeable result of Defendants' acts and omission, Defendants caused personal and other injuries to Plaintiff.

48. Plaintiff has been injured and is entitled to recover general and special damages in amounts to be determined at trial.

**THIRD CLAIM FOR RELIEF: NEGLIGENT MISREPRESENTATION**

49. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

50. Defendants, individually and collectively, represented to Plaintiff that medical procedures, testing, and follow-up visits were medically necessary.

51. Defendants' representations that Plaintiff's medical procedures, testing, and follow-up visits were medically necessary was, in fact, not true.

52. Defendants failed to use reasonable care to determine whether the representations regarding the necessity of Plaintiff's medical care was true.

53. Defendants were in a better position than Plaintiff to know the true facts regarding Plaintiff's medical procedures, testing, and follow-up care.

54. Defendants had a financial interest in performing medically unnecessary procedures, testing, and follow-up care on Plaintiff.

55. Plaintiff relied on Defendants' representations, and it was reasonable for her to do so.

56. Plaintiff has therefore been injured as a result of relying on Defendants' representations and is entitled to recover general and special damages in an amount to be determined at trial.

**FOURTH CLAIM FOR RELIEF: NEGLIGENT CREDENTIALING**

57. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

58. Defendant St. Mark's owes a duty to patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges to them. It also has the duty to periodically monitor and review the qualifications and competency of its medical staff.

59. Defendant St. Mark's breached its duty to exercise reasonable care in its selection of its medical staff, and in granting specialized privileges to and periodically monitoring and reviewing the qualifications and competency of its medical staff.

60. As a sole, proximate, and foreseeable result of its breach, Defendant St. Mark's caused harm to Plaintiff.

61. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**FIFTH CLAIM FOR RELIEF: FRAUDULANT NON-DISCLOSURE/CONCEALMENT**

62. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

63. Defendants owed a duty to Plaintiff to disclose important facts, such as the medical necessity of Plaintiff's medical care, to Plaintiff.

64. Defendants knew that the medical care Defendants provided to Plaintiff was not medically necessary, and failed to disclose this to Plaintiff.

65. Plaintiff did not know that the medical care provided by Defendants was not medically necessary.

66. Defendants' failure to disclose the fact that Plaintiff's medical care was not necessary was a substantial factor in causing Plaintiff's damages. Had Plaintiff known that her closure surgery was not necessary, Plaintiff would not have undergone the surgery.

67. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SIXTH CLAIM FOR RELIEF: FRAUD**

68. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

69. At all relevant times, Defendants had a duty and obligation to disclose to Plaintiff true facts concerning the medical care provided to Plaintiff by Defendants.

70. Defendants intentionally concealed material facts concerning Plaintiff's medical care from Plaintiff including, but not limited to the following:

a. Falsifying Plaintiff's medical records to indicate that she was an appropriate candidate for closure;

b. Performing medically unnecessary medical procedures with a device that was not FDA approved for this use; and

c. Concealing from Plaintiff that medical procedures, testing, and follow-up care was unnecessary.

71. Defendants made false statements and misrepresentations about important facts regarding Plaintiff's medical care.

72. Defendants made these false statements and misrepresentations described above knowing that the statements were false, or with reckless disregard for their truth.

73. Defendants made the false statements and misrepresentations to Plaintiff, with the intent that Plaintiff would rely on the statements.

74. Plaintiff did reasonably rely on the false statements and misrepresentations made by Defendants.

75. As a sole, proximate, and foreseeable result of Defendants' false statements and misrepresentations, Plaintiff has suffered personal injuries, including but not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

**SEVENTH CLAIM FOR RELIEF: CIVIL CONSPIRACY**

76. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

77. Defendants were acting in a conspiracy to commit fraud, thereby increasing their profits through the performance of medically unnecessary procedures on patients, including Plaintiff.

78. There was an agreement and meeting of the minds among Defendant Sorensen, Defendant SCG, and Defendant St. Mark's to misrepresent the need for and induce patients, including Plaintiff, into undergoing medically unnecessary procedures, testing, and follow-up. Defendants agreed to act in concert in making these misrepresentations about the necessity of medical procedures to Plaintiff.

79. There were multiple unlawful, overt acts by Defendant Sorensen, Defendant SCG, and Defendant St. Mark's in furtherance of their scheme, including without limitation, Defendants' fraud.

80. As a result of this conspiracy, Defendant Sorensen, Defendant SCG, and Defendant St. Mark's, should be held jointly and severally liable for the conduct of the other co-conspirators and the damages that Plaintiff sustained as a proximate result thereof, including without limitation personal injuries and other injuries.

81. Plaintiff would further show that Defendant Sorensen and Defendant SCG were operating as alter egos for the purpose of perpetrating the above described conspiracy. There was such a unity of interest and ownership that the separate personalities of the company and the individual did not exist. Observing the corporate form will sanction this conspiracy, promote injustice, and allow an inequitable result.

**EQUITABLE TOLLING/FRAUDULENT CONCEALMENT**

82. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

83. Because of Defendants' concealment of material facts and misleading conduct, Plaintiff was not aware of her causes of action.

84. Defendants took affirmative steps to conceal Plaintiff's cause of action. Given Defendants' concealment and misleading conduct, a reasonable plaintiff would not have discovered the cause of action earlier.

85. Neither Sorenson, nor St. Mark's ever notified Plaintiff that she had received an unnecessary procedure, that she was never indicated for the surgery to begin with, that the device implanted into Plaintiff was never medically necessary, was retained in her body for no medical purpose, and that the informed consent contained fraudulent, misleading, and/or incomplete statements. Neither Sorenson, nor St. Mark's, ever compensated Plaintiff for the unnecessary medical surgery she underwent by reimbursing the costs of the procedure.

86. Neither Sorensen, nor St. Mark's, ever made a public statement, sent a letter, made a public announcement, or issued a press release to inform patients, such as Plaintiff, that they may have had medically unnecessary closures.

87. Defendants' misrepresentations and misleading conduct constitutes fraudulent concealment that tolls any proffered statute of limitation that may otherwise bar the recovery sought by Plaintiff.

88. Plaintiff did not know, nor should have known, of the causes of action against Defendants prior to being put on notice of Defendants' potential liability recently. She neither discovered, nor reasonably should have discovered, the facts underlying her causes of action before any proffered statute of limitations period expired.

89. As a result of Defendants' concealment of the true character, quality and nature of their conduct, they are estopped from relying on any statute of limitations defense. Defendants' affirmative acts and omissions, before, during, and/or after their actions causing Plaintiff's injury prevented Plaintiff from discovering the injury or cause thereof until recently. Such conduct tolls the limitations pursuant to the Utah Health Care Malpractice Act 78B-3-404(b).

90. Defendants' conduct, because it was purposely committed, was known or should have been known by them to be dangerous, heedless, reckless, and without regard to the consequences or the rights and safety of Plaintiff.

## PRAYER FOR RELIEF

**WHEREFORE**, Plaintiff prays for a judgment (under URCP: Tier 3) against Defendants in an amount to be determined by the trier of fact for the following damages:

a. For special damages in an amount to be determined at trial;

b. For general damages in an amount to be determined at trial;

c. For pre and post judgment interest on all special damages pursuant to Utah law;

d. For costs and attorney fees to the extent allowed by law; and

e. For such other relief as the Court deems appropriate.

RESPECTFULLY SUBMITTED this 14th day of December 2017.

/s/ Rhome D. Zabriskie
**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

**FLEMING, NOLEN & JEZ, LLP**
Rand P. Nolen (Pro Hac Vice submission in progress)
David L. Hobbs (Pro Hac Vice submission in progress)
2800 Post Oak Blvd., Suite 4000
Houston, TX 77056-6109
Telephone: (713) 621-7944
Facsimile: (713) 621-9638
Email: rand_nolen@fleming-law.com
Email: david_hobbs@fleming-law.com

*Counsel for Plaintiff*

**CERTIFICATE OF SERVICE**

I hereby certify that that a true and exact copy of the foregoing has been served on the following via the Court's ECF filing system and/or Email on 14th day of December, 2017:

Eric P. Schoonveld
Tawni J. Anderson
Nathan E. Dorsey
Hall Prangle & Schoonveld, LLC
111 East Broadway, Suite 700
Salt Lake City, UT 84111
Phone: 801-320-0900
Fax: 801-320-0896
eric@hpslaw.com
tanderson@hpslaw.com
ndorsey@hpslaw.com

*Attorneys for St. Mark's Hospital*

Michael J. Miller

Strong & Hanni
102 South 200 East, Suite 800
Salt Lake City, UT 84111
mmiller@strongandhanni.com

*Attorney for Defendants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

/s/ Rhome D. Zabriskie
Rhome D. Zabriskie

# Addendum F

**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

*Counsel for Plaintiff*

**IN THE THIRD JUDICIAL DISTRICT COURT – SALT LAKE CITY**

**SALT LAKE COUNTY, STATE OF UTAH**

| | | |
|---|---|---|
| **JOHANNAH BRIGHT,**<br><br>Plaintiff,<br><br>v.<br><br>**SHERMAN SORENSEN, M.D.; SORENSEN CARDIOVASCULAR GROUP; AND ST. MARK'S HOSPITAL**,<br><br>Defendants. | ) | **FIRST AMENDED COMPLAINT (Tier 3 Filing)**<br><br>**(Jury Demanded)**<br><br>**Civil No. 170906790**<br><br>**Judge: Laura Scott** |

**COMES NOW** Plaintiff, by and through counsel, and hereby complain for causes of action against the above-captioned Defendants, alleging as follows:

## PARTIES, JURISDICTION, AND VENUE

1. Plaintiff Johannah Bright is, and at all relevant times has been, a resident of Davis County, State of Utah.

2. Defendant SHERMAN SORENSEN, M.D. was, at all relevant times, a licensed physician providing health care services in Salt Lake County, State of Utah.

3. Defendant SORENSEN CARDIOVASCULAR GROUP (SCG), was at all material times, a Utah professional corporation in the business of providing health care services to residents of Utah. Defendant SCG's principal place of business is located at 5169 Cottonwood Street, No. 610, Murray, Utah. Defendant Sherman Sorensen owned and operated SCG as his primary medical practice.

4. Defendant ST. MARK'S HOSPITAL. (St. Mark's) is a for-profit corporation based in Salt Lake City, Utah with its principal place of business and corporate office at 1200 E 3900 S Salt Lake City, UT 84124. St. Mark's Registered Agent for Service CT Corporation System, 1108 E South Union Ave., Midvale UT 84047.

5. Upon information and belief, at all material times, each of the Defendants were, or may have been, an agent, servant, employer, employee, joint venture, partner, and/or alter ego of one or more of each of the remaining Defendants, and were at all times acting within the purpose and scope of such agency, servitude, joint venture, alter ego, partnership, or employment, and with the authority, consent, approval, and/or ratification of each remaining Defendant.

6. At all material times, Defendants were health care providers within the meaning of the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-401 et seq., and each Defendant provided health care services to Plaintiff.

7. This Court has jurisdiction over this action pursuant to Utah Code Ann. § 78A-5-102.

8. Venue is proper in this Court pursuant to Utah Code Ann. § 78B-3-307.

9. In bringing this action, Plaintiff complied with all statutory requirements regarding pre-litigation review of this matter as set forth in the Utah Health Care Malpractice Act, Utah Code Ann. § 78B-3-416.

## BACKGROUND

10. This case is one of more than a thousand cases that are presently working their way through the prelitigation process, which involve the medically unnecessary heart surgery by Dr. Sherman Sorensen related to two kinds of holes in the heart. One is called an atrial septal defect (ASD), and the other is a patent foramen ovale (PFO). Both are holes in the wall of tissue (septum) between the left and right upper chambers of the heart (atria). An ASD is considered a birth defect and is a failure of the septal tissue to form between the atria, PFOs can only occur after birth when the foramen ovale fails to close.[1]

11. Life threatening ASD's are generally discovered at birth and corrected immediately. However, there are billions of adults who have small openings between the left and right atriums of their hearts. The foramen ovale is an opening located in the wall separating the two upper chambers of the heart, the atrial septum, which is used during fetal circulation to redirect blood through the heart. In 75% of the population, the foramen ovale closes at birth when increased blood pressure on the left side of the heart forces the opening to close. In those cases, where the foramen ovale does not close at birth, a patent foramen ovale (PFO) results.

12. Approximately 25% of the healthy population have a PFO and will never require any treatment or evaluation. Apart from extremely rare cases, patients with a PFO remain completely unaware of the presence of the PFO because it's almost never associated with symptoms. Persistent patency of the foramen ovale is considered a normal anatomic variation.

[1] Dr. Sorensen at times earlier in his career referred to these two conditions interchangeably, but for insurance reimbursement purposes decided that all PFO's were ASD's later in his practice. Either way, and no matter what he called them, he closed holes indiscriminately and without medical justification on thousands of people, including the Plaintiff.

13. Only if a patient has a recurrence of cryptogenic (originating from unexplained causes) stroke or transient ischemic attack (TIA), likely due to paradoxical embolization through a PFO, and despite optimal medical therapy, may it be appropriate to close the PFO. Generally, this closure is performed through a percutaneous surgical procedure. In the percutaneous procedure, a patient undergoes a cardiac catheterization to determine the size and location of the PFO.

14. There has long been general agreement in the medical community—as far back as 2003—that PFO closure is not medically necessary, except in the limited circumstances where there is a confirmed diagnosis of a recurrent cryptogenic stroke or TIA, despite optimum medical management. At all material times, no widely accepted medical group specializing in cardiology in the United States has ever recommended, advised, or suggested that closure is appropriate for stroke or migraine prevention to patients that have not had recurrent cryptogenic strokes.

## GENERAL ALLEGATIONS

15. The following general allegations are common to all claims alleged herein:

16. As noted, Defendant Dr. Sorensen is a cardiologist and was practicing interventional cardiology. He had privileges at Defendant St. Mark's and at other hospitals. From roughly 2002 to 2012, Defendant Sorensen performed more than 4,000 PFO and ASD closures, many of those at St. Mark's. Dr. Sorensen performed the procedures at a rate that dwarfed the rest of the country by a factor of ten-to-twenty fold, making him a true outlier.

17. The administration at St. Mark's was on notice because of the sheer volume of the procedures performed by Defendant Sorensen and because of complaints from other practitioners and employees that Defendant Sorensen was engaged in a practice of regularly performing

unnecessary, invasive cardiac procedures on his patients. St. Mark's ignored obvious warnings to halt these procedures so that it could secure and maintain a lucrative stream of income.

18. Further, during the hiring and credentialing process at St. Mark's, Sorensen advised St. Mark's representatives of how he would perform closures and under what conditions. And a result, St. Mark's was aware that he would be performing unnecessary closures on patients that did not have recurrent cryptogenic strokes.

19. Further, Sorensen's cardiac privileges at another hospital were suspended on or about June 27, 2011, following an internal investigation concluded that Sorensen had performed multiple, medically unnecessary PFO closures and that Sorensen represented a threat to the health and safety of the patients treated. And St. Mark's CEO Steve Bateman and physician liaison Nikki Gledhill were aware of Sorensen's suspension.

20. Defendants Sorensen and St. Mark's created false statements and documents to conceal the fact that Sorensen was performing medically unnecessary closures. These statements include documenting migraine or stroke history where none existed. For instance, Sorensen often created medical charts that falsely reflected that the patients had suffered from, or were at risk of suffering from, recurrent cryptogenic stroke in order to get insurance to pay for the procedure. The effort to disguise the true diagnosis and reason for the closures shows that Sorensen was always aware of and understood the true standard of care for these procedures.

21. Sorensen would routinely mislead his patients, who had no previous strokes or TIAs, into believing that they were at extreme risk of debilitating stroke because of their PFO or ASD. He would further mislead them that a closure procedure would be effective and was medically necessary in order to prevent strokes. These misrepresentations were made to the vast majority of his patients, including Plaintiff.

22. Despite the fact that St. Mark's knew that Sorensen was performing medically unnecessary closures, and knew that Sorensen had been suspended for performing medically unnecessary closures at another hospital, St. Mark's Hospital continued to court Sorensen's business, provide a platform and assistance to Sorensen, and advertise and promote Sorensen and closure practice to the public for its own financial gain.

23. In particular, the catheterization lab staff at St. Mark's became financially dependent on Sorensen's incredible volume. The majority of patients at St. Mark's cardiac catheterization laboratory came from Sorensen, dwarfing all other cardiology business at St. Mark's. As a result, St. Mark's provided special treatment to Sorensen with staffing and scheduling in its catheterization lab, often to the detriment of true cardiac patients and other cardiologists. St. Mark's also provided open access for PFO industry representatives to the lab and personnel. Industry provided order-in meals were available to those catheterization lab personnel that were willing to share in the largesse.

24. Ultimately, St. Mark's made a deliberate and conscious decision not to inform patients that they may have had a medically unnecessary surgery, and chose not to reimburse Plaintiff, her insurance company, or any of its other patients who had procedures performed unnecessarily. Instead, St. Mark's kept the profits for itself.

**PLAINTIFF'S CLOSURE AND INJURIES**

25. On 9-21-07, Ms. Bright was seen in referral by Sorensen for migraine headaches and a transesophageal echocardiogram reported to show right to left shunting across the atrial septum. On 9-21-07, in Dr. Sorensen's office, Ms. Bright underwent a transthoracic echocardiogram (TTE) with bubble study and a transcranial doppler study (TCD). The echocardiogram was interpreted to show "severe rest and valsalva shunt by bubble study." The

TCD was interpreted to show conductance grade of 4/5 at rest and 5/5 with calibrated respiratory strain. Dr. Sorensen noted that the patient has described "minor palpitations."

26. On 10-1-07, a brain MRI is performed at Western Neurological Associates. It was interpreted as "normal contrast-enhanced MRI of the brain."

27. On 11-28-07, Ms. Bright was seen in office follow-up by Dr. Sorensen. He did not recommend closure of her septal defect: "The options for closure for stroke prevention [were] reviewed but she [did] not have risk stratification features other than migraine." Dr. Sorensen asked Ms. Bright to consider enrolling in a randomized trial called the PREMIUM trial. That never occurred.

28. On 11-4-09, a repeat consult was performed by Dr. Sorensen. Dr. Sorensen's neurologic exam on Ms. Bright was not comprehensive. For instance, it did not include a sensory exam. In the impression section of this history and physical, Dr. Sorensen dictated: "This woman has high risk features for stroke which include the presence of progressive migraine, moderately severe persistent shunting, severe Valsalva shunting, and an interatrial septal aneurysm." This note was contrary to his previous note of 11-28-07 in which he dictated: "but she does not have risk stratification features other than migraine."

29. On 12-15-09, Dr. Sorensen performed an intracardiac echo-guided septal defect closure. He deployed a 20 mm Gore HELEX device.

30. On 3-18-10, Ms. Bright underwent a TTE and a TCD in Dr. Sorensen's office. Both studies demonstrated the presence of a residual shunt. A bubble study during the echocardiogram showed "mild right to left shunt at rest" and moderate right to left shunt" after valsalva. The TCD is interpreted to show a conductance grade of 2/5 at rest and 4/5 during calibrated respiratory strain. Dr. Sorensen's TCD reports gave slightly different guidelines for a "diagnostic TCD"

versus a "post-device TCD." In the diagnostic TCD, a conductance grade of 4/5 is termed a "mild to moderate" shunt with moderate probability for PFO, ASD, or AVM. There was a "low risk for stroke." In the post device TCD, a conductance grade of 4/5 is termed a "mild residual shunt." A conductance grade of 5 or 5+/5 in a post device TCD is termed a "significant residual shunt" and "further evaluation is indicated."

31. On or about June 28, 2010, Ms. Bright had a 6 month follow TTE and TCD. These studies were interpreted to show a decrease in the magnitude of the residual shunt. The echocardiogram was interpreted to show no right to left shunt at rest and a mild right to left shunt with valsalva. The TCD was interpreted to show 1/5 conductance grade at rest and 3/5 conductance grade with calibrated respiratory strain. The guidelines included in the TCD report indicates that a 3/5 conductance grade means "no significant shunt."

32. The accepted indications for closure of an atrial septal defect include right ventricular chamber enlargement, orthodeoxia-platypnea, and paradoxical embolism. Ms. Bright did not have the first two. And, Dr. Sorensen failed to perform the appropriate assessment as to the last.

33. In a patient with strong or definitive evidence for embolic stroke, the standard of care requires a comprehensive evaluation for all of the causes of embolic stroke. This was not performed by Dr. Sorensen in his care of Ms. Bright. A comprehensive evaluation for causes of "cryptogenic" stroke includes an MRI of the brain, imaging of the extra cranial and intracranial cerebral arteries, 3-4 week rhythm monitoring to look for paroxysmal atrial fibrillation, imaging of the aorta to look for atherosclerotic disease, lower extremity venous doppler/ultrasound, MRV of the abdominal and pelvic veins, and a hyper coagulability workup. Here, Dr. Sorensen did not meet this standard of care by, among other things, failing to give the details of alleged trans

ischemic attacks that Sorensen (not a neurologist) diagnosed, failing to get a neurology consultation, failing to have neuro-cognitive testing performed to document "cognitive decline," and failing to repeat a brain MRI to look for objective evidence of stroke. In short, Sorensen did not perform the required comprehensive evaluation.

34. To persuade Ms. Bright to undergo closure, Sorensen represented to her that she was at high risk of a debilitating stroke due to the presence of her PFO/ASD and that closure was medically necessary. In truth, the mere presence of the defect, without more, including a history of cryptogenic stroke, is not a significant risk factor for stroke. Further, Sorensen passed out a Patient Information Patent Foreman Ovale (PFO) handout to Ms. Bright. Sorensen's patient literature contained fraudulent misrepresentations, unsupported data and statistics, outright falsehoods, and other misleading statements, such as the following:

- "Until recently, 40% of all strokes were unknown cause. We now know that most of these unexplained strokes may be caused by a PFO (Patent Foramen Ovale)"
- "Strokes resulting from septal defects have a 50% mortality rate."
- "PFO is diagnosed in 50-70% of patients with stroke of unknown cause"
- "Continued lifelong risk of stroke ranging from 2-9% each year."
- "Stroke reduction to less than 1%"
- "Septal Defect Closure Safety and Efficacy"
- "Our rigorous Program requirements assure that you are informed and receive the safest and most effective treatment"

In addition, to the handout Sorensen made other misrepresentations to Ms. Bright both orally and in writing. These misrepresentations include:

- "Our approach is a preventative strategy. It is scientifically based, but it is an aggressive strategy." In fact, Dr. Sorenson's method has never been accepted in any scientific journal, organization, been approved for a randomized clinical trial, and/or the peer review process for his data and proposed indication for PFO closure. "We, therefore follow a preventative strategy and risk stratify patients based on the studies…proposed by the American Academy of Neurology." That is false; the AAN did not recommend closure outside of clinical trials and encouraged patients to participate in research protocols.
- "8 studies demonstrate that very high flow is the main feature of stroke risk." In fact, the AAN Practice Parameter did not find an association, much less causation, of shunting and risk of stroke recurrence.
- "Randomized trials are not available currently." In reality, the Closure I trial was opened in Salt Lake City, Utah. It was halted due to Defendant Sorensen's medically unnecessary off-label PFO procedures of patients outside the trial.
- "Coumadin is considered to be unsafe and ineffective…based on studies." In fact, the SPIRIT, WASID and WARRS studies referenced by Sorensen showed no such thing.
- Sorenson certified that his echocardiography lab was certified by ICAEL (Intersocietal Commission for Accreditation Laboratories) using the ICAEL logo on his echochardiogram. In fact, his lab was never accredited by ICAEL and this was false.

These false statements were intended to and did in fact induce Ms. Bright to undergo closure at St. Mark's by inducing fear of an imminent and debilitating stroke, downplaying safer and accepted treatment options, misrepresenting the indication for closure, and downplaying the risks of closure.

35. Despite St. Mark's awareness of Sorensen's fraudulent and/or negligent practices, it did nothing to notify Ms. Bright. Instead, St. Mark's actively allowed Sorensen's practice to continue in order to profit from the thousands of unnecessary procedures performed on patients like Ms. Bright. In fact, St. Mark's has to this day actively concealed its knowledge about Sorensen's rogue and fraudulent practices at its facility from patients, third party payers, and the public, and has retained the money earned off of Sorensen's medically unnecessary surgeries.

36. Ms. Bright could not have known that the information provided by Defendants was false. Instead, she trusted that Defendants Sorensen and St. Mark's, as her health care providers, were being truthful. Further, even if she had been aware of some of the factual mischaracterizations, as a non-expert she could not have understood their implications as it relates the appropriateness of her medical treatment.

37. Because of Defendants' fraudulent statements and omissions, Ms. Bright was until recently unaware of her cause of action. In fact, Ms. Bright only learned of the Defendants' misconduct as a result lawyer advertising. Her diligent investigation resulted in the noticing and filing of this action within the statutory period.

38. Because of Defendants' conduct, Ms. Bright suffered significant damages, including:

i. undergoing an unnecessary surgical procedure and hospital stay,

ii. paying significant medical expenses to Defendants,

iii. physical pain, and

emotional anguish as a result of being told she was at immediate risk of a debilitating or even deadly stroke.

**FIRST CLAIM FOR RELIEF: NEGLIGENCE (HEALTH CARE MALPRACTICE)**

39. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

40. Defendants, individually, collectively, and through the acts and omissions of their agents, servants, employees, physicians, nurses, therapists, and technologists (hereinafter collectively "Defendants") accepted Plaintiff as a patient, and thereby assumed various duties of care.

41. At all relevant times, Defendants held themselves out as being able to provide full care and treatment for patients requiring medical care of the type that Plaintiff required.

42. The degree of care and treatment provided to Plaintiff fell below the acceptable standards of care for the types of medical care and treatment required by Plaintiff and provided by Defendants.

43. Specifically, Defendants breached the applicable standards of care in multiple ways including, but not limited to:

a. Falsifying Plaintiff's medical records to indicate that Plaintiff was an appropriate candidate for closure;
b. Misleading Plaintiff regarding the risks and benefits associated with closure and regarding the necessity of treatment;
c. Failing to obtain an adequate history which resulted in an improper medical diagnosis that Plaintiff was an appropriate candidate for closure;
d. Failing to conduct an adequate physical and to obtain appropriate diagnostic testing, which resulted in an improper medical diagnosis that Plaintiff was an appropriate

candidate for PFO closure; Performing a medically unnecessary medical procedure with a device that was not FDA approved for this use; and

44. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Defendants caused Plaintiff to undergo unnecessary medical procedures, testing, and follow-up visits, incur unnecessary medical expenses, and experience physical injuries and emotional anguish.

45. As a sole, proximate, and foreseeable result of Defendants' acts and omissions, Plaintiff has suffered personal injuries, including by not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

46. Plaintiff has therefore been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SECOND CLAIM FOR RELIEF: NEGLIGENCE**

47. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

48. At all relevant times, Defendants owed Plaintiff various duties of care, including but not limited to common law and statutory duties.

49. Defendants, individually and collectively, breached these duties of care.

50. As a sole, proximate, and foreseeable result of Defendants' acts and omission, Defendants caused personal and other injuries to Plaintiff.

51. Plaintiff has been injured and is entitled to recover general and special damages in amounts to be determined at trial.

**THIRD CLAIM FOR RELIEF: NEGLIGENT MISREPRESENTATION**

52. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

53. Defendants, individually and collectively, represented to Plaintiff that medical procedures, testing, and follow-up visits were medically necessary.

54. Defendants' representations that Plaintiff's medical procedures, testing, and follow-up visits were medically necessary was, in fact, not true.

55. Defendants failed to use reasonable care to determine whether the representations regarding the necessity of Plaintiff's medical care was true.

56. Defendants were in a better position than Plaintiff to know the true facts regarding Plaintiff's medical procedures, testing, and follow-up care.

57. Defendants had a financial interest in performing medically unnecessary procedures, testing, and follow-up care on Plaintiff.

58. Plaintiff relied on Defendants' representations, and it was reasonable for her to do so.

59. Plaintiff has therefore been injured as a result of relying on Defendants' representations and is entitled to recover general and special damages in an amount to be determined at trial.

**FOURTH CLAIM FOR RELIEF: NEGLIGENT CREDENTIALING**

60. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

61. Defendant St. Mark's owes a duty to patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges to them. It also has the duty to periodically monitor and review the qualifications and competency of its medical staff.

62. Defendant St. Mark's breached its duty to exercise reasonable care in its selection of its medical staff, and in granting specialized privileges to and periodically monitoring and reviewing the qualifications and competency of its medical staff.

63. As a sole, proximate, and foreseeable result of its breach, Defendant St. Mark's caused harm to Plaintiff.

64. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**FIFTH CLAIM FOR RELIEF: FRAUDULENT NON-DISCLOSURE/CONCEALMENT**

65. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

66. Defendants owed a duty to Plaintiff to disclose important facts, such as the medical necessity of Plaintiff's medical care, to Plaintiff.

67. Defendants knew that the medical care Defendants provided to Plaintiff was not medically necessary, and failed to disclose this to Plaintiff.

68. Plaintiff did not know that the medical care provided by Defendants was not medically necessary.

69. Defendants' failure to disclose the fact that Plaintiff's medical care was not necessary was a substantial factor in causing Plaintiff's damages. Had Plaintiff known that her closure surgery was not necessary, Plaintiff would not have undergone the surgery.

70. Plaintiff has been injured and is entitled to recover general and special damages in an amount to be determined at trial.

**SIXTH CLAIM FOR RELIEF: FRAUD**

71. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

72. At all relevant times, Defendants had a duty and obligation to disclose to Plaintiff true facts concerning the medical care provided to Plaintiff by Defendants.

73. Defendants intentionally concealed material facts concerning Plaintiff's medical care from Plaintiff including, but not limited to the following:

a. Falsifying Plaintiff's medical records to indicate that she was an appropriate candidate for closure;

b. Performing medically unnecessary medical procedures with a device that was not FDA approved for this use; and

c. Concealing from Plaintiff that medical procedures, testing, and follow-up care was unnecessary.

74. Defendants made false statements and misrepresentations about important facts regarding Plaintiff's medical care.

75. Defendants made these false statements and misrepresentations described above knowing that the statements were false, or with reckless disregard for their truth.

76. Defendants made the false statements and misrepresentations to Plaintiff, with the intent that Plaintiff would rely on the statements.

77. Plaintiff did reasonably rely on the false statements and misrepresentations made by Defendants.

78. As a sole, proximate, and foreseeable result of Defendants' false statements and misrepresentations, Plaintiff has suffered personal injuries, including but not limited to unnecessary medical procedures, testing, follow-up visits, medical expenses, and emotional anguish.

**SEVENTH CLAIM FOR RELIEF: CIVIL CONSPIRACY**

79. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

80. Defendants were acting in a conspiracy to commit fraud, thereby increasing their profits through the performance of medically unnecessary procedures on patients, including Plaintiff.

81. There was an agreement and meeting of the minds among Defendant Sorensen, Defendant SCG, and Defendant St. Mark's to misrepresent the need for and induce patients, including Plaintiff, into undergoing medically unnecessary procedures, testing, and follow-up. Defendants agreed to act in concert in making these misrepresentations about the necessity of medical procedures to Plaintiff.

82. There were multiple unlawful, overt acts by Defendant Sorensen, Defendant SCG, and Defendant St. Mark's in furtherance of their scheme, including without limitation, Defendants' fraud.

83. As a result of this conspiracy, Defendant Sorensen, Defendant SCG, and Defendant St. Mark's, should be held jointly and severally liable for the conduct of the other co-conspirators and the damages that Plaintiff sustained as a proximate result thereof, including without limitation personal injuries and other injuries.

84. Plaintiff would further show that Defendant Sorensen and Defendant SCG were operating as alter egos for the purpose of perpetrating the above described conspiracy. There was such a unity of interest and ownership that the separate personalities of the company and the individual did not exist. Observing the corporate form will sanction this conspiracy, promote injustice, and allow an inequitable result.

**EQUITABLE TOLLING/FRAUDULENT CONCEALMENT**

85. Plaintiff refers to and incorporates the preceding paragraphs as if set forth fully herein.

86. Because of Defendants' concealment of material facts and misleading conduct, Plaintiff was not aware of her causes of action.

87. Defendants took affirmative steps to conceal Plaintiff's cause of action. Given Defendants' concealment and misleading conduct, a reasonable plaintiff would not have discovered the cause of action earlier.

88. Neither Sorenson, nor St. Mark's ever notified Plaintiff that she had received an unnecessary procedure, that she was never indicated for the surgery to begin with, that the device implanted into Plaintiff was never medically necessary, was retained in her body for no medical purpose, and that the informed consent contained fraudulent, misleading, and/or incomplete statements. Neither Sorenson, nor St. Mark's, ever compensated Plaintiff for the unnecessary medical surgery she underwent by reimbursing the costs of the procedure.

89. Neither Sorensen, nor St. Mark's, ever made a public statement, sent a letter, made a public announcement, or issued a press release to inform patients, such as Plaintiff, that they may have had medically unnecessary closures.

90. Defendants' misrepresentations and misleading conduct constitutes fraudulent concealment that tolls any proffered statute of limitation that may otherwise bar the recovery sought by Plaintiff.

91. Plaintiff did not know, nor should have known, of the causes of action against Defendants prior to being put on notice of Defendants' potential liability recently. She neither discovered, nor reasonably should have discovered, the facts underlying her causes of action before any proffered statute of limitations period expired.

92. As a result of Defendants' concealment of the true character, quality and nature of their conduct, they are estopped from relying on any statute of limitations defense. Defendants' affirmative acts and omissions, before, during, and/or after their actions causing Plaintiff's injury prevented Plaintiff from discovering the injury or cause thereof until recently. Such conduct tolls the limitations pursuant to the Utah Health Care Malpractice Act 78B-3-404(b).

93. Defendants' conduct, because it was purposely committed, was known or should have been known by them to be dangerous, heedless, reckless, and without regard to the consequences or the rights and safety of Plaintiff.

## PRAYER FOR RELIEF

**WHEREFORE**, Plaintiff prays for a judgment (under URCP: Tier 3) against Defendants in an amount to be determined by the trier of fact for the following damages:

a. For special damages in an amount to be determined at trial;

b. For general damages in an amount to be determined at trial;

c. For pre and post judgment interest on all special damages pursuant to Utah law;

d. For costs and attorney fees to the extent allowed by law; and

e. For such other relief as the Court deems appropriate.

RESPECTFULLY SUBMITTED this 21st day of December 2017.

/s/ Rhome D. Zabriskie
**Rhome D. Zabriskie**
**ZABRISKIE LAW FIRM, LLC**
899 North Freedom Blvd, Suite 200
Provo, Utah 84604
Tel: (801) 375-7680
Fax: (801) 375-7686
Email: rhomelawyer@yahoo.com

**FLEMING, NOLEN & JEZ, LLP**
Rand P. Nolen (Pro Hac Vice submission in progress)
David L. Hobbs (Pro Hac Vice submission in progress)
2800 Post Oak Blvd., Suite 4000
Houston, TX 77056-6109
Telephone: (713) 621-7944
Facsimile: (713) 621-9638
Email: rand_nolen@fleming-law.com
Email: david_hobbs@fleming-law.com

*Counsel for Plaintiff*

**CERTIFICATE OF SERVICE**

I hereby certify that that a true and exact copy of the foregoing has been served on the following via the Court's ECF filing system and/or Email on 21st day of December, 2017:

Eric P. Schoonveld
Tawni J. Anderson
Nathan E. Dorsey
Hall Prangle & Schoonveld, LLC
111 East Broadway, Suite 700
Salt Lake City, UT 84111
Phone: 801-320-0900
Fax: 801-320-0896
eric@hpslaw.com
tanderson@hpslaw.com
ndorsey@hpslaw.com

*Attorneys for St. Mark's Hospital*

Michael J. Miller
Strong & Hanni
102 South 200 East, Suite 800
Salt Lake City, UT 84111
mmiller@strongandhanni.com

*Attorney for Defendants Sherman Sorensen, M.D. and Sorensen Cardiovascular Group*

/s/ Rhome D. Zabriskie
Rhome D. Zabriskie

# Addendum G

West's Utah Code Annotated
Title 78b. Judicial Code
Chapter 3. Actions and Venue
Part 4. Utah Health Care Malpractice Act (Refs & Annos)

U.C.A. 1953 § 78B-3-404
Formerly cited as UT ST § 78-14-4

# § 78B-3-404. Statute of limitations--Exceptions--Application

Currentness

(1) A malpractice action against a health care provider shall be commenced within two years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered the injury, whichever first occurs, but not to exceed four years after the date of the alleged act, omission, neglect, or occurrence.

(2) Notwithstanding Subsection (1):

(a) in an action where the allegation against the health care provider is that a foreign object has been wrongfully left within a patient's body, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the existence of the foreign object wrongfully left in the patient's body, whichever first occurs; or

(b) in an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs.

**Credits**
Laws 2008, c. 3, § 710, eff. Feb. 7, 2008; Laws 2012, c. 384, § 4, eff. May 8, 2012.

Notes of Decisions (131)

U.C.A. 1953 § 78B-3-404, UT ST § 78B-3-404
Current with the 2018 Third Special Session.

**End of Document**

# Addendum H

West's Utah Code Annotated
State Court Rules
Utah Rules of Civil Procedure (Refs & Annos)
Part III. Pleadings, Motions, and Orders

Utah Rules of Civil Procedure, Rule 9

# RULE 9. PLEADING SPECIAL MATTERS

Currentness

**(a) Capacity or Authority to Sue; Legal Existence.**

(1) *In General.* Except when required to show that the court has jurisdiction, a pleading need not allege:

(A) a party's capacity to sue or be sued;

(B) a party's authority to sue or be sued in a representative capacity; or

(C) the legal existence of an organized association of persons that is made a party.

(2) *Raising Those Issues.* To raise any of those issues, a party must do so by a specific denial, which must state any supporting facts that are peculiarly within the party's knowledge.

**(b) Unknown parties.**

(b)(1) *Designation.* When a party does not know the name of an opposing party, it may state that fact in the pleadings, and designate the opposing party in a pleading by any name. When the true name of the opposing party becomes known, the pleading must be amended.

(b)(2) *Descriptions of interest in quiet title actions.* If one or more parties in an action to quiet title are designated in the caption as "unknown," the pleadings may describe the unknown persons as "all other persons unknown, claiming any right, title, estate or interest in, or lien upon the real property described in the pleading adverse to the complainant's ownership, or clouding its title."

**(c) Fraud, mistake, condition of the mind.** In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally.

  

**(d) Conditions precedent.** In pleading conditions precedent, it is sufficient to allege generally that all conditions precedent have been performed or have occurred. When denying that a condition precedent has been performed or has occurred, a party must do so with particularity.

**(e) Official document or act.** In pleading an official document or official act it is sufficient to allege that the document was legally issued or the act was legally done.

**(f) Judgment.** In pleading a judgment or decision of a domestic or foreign court, a judicial or quasi judicial tribunal, or a board or officer, it is sufficient to plead the judgment or decision without showing jurisdiction to render it.

**(g) Time and place.** An allegation of time or place is material when testing the sufficiency of a pleading.

**(h) Special damage.** If an item of special damage is claimed, it must be specifically stated.

**(i) Statute of limitations.** In pleading the statute of limitations it is not necessary to state the facts showing the defense but it may be alleged generally that the cause of action is barred by the statute, referring to or describing the statute by section number, subsection designation, if any, or designating the provision relied on sufficiently to identify it.

**(j) Private statutes; ordinances.** In pleading a private statute, an ordinance, or a right derived from a statute or ordinance, it is sufficient to refer to the statute or ordinance by its title and the day of its passage or by its section number or other designation in any official publication of the statute or ordinance. The court will take judicial notice of the statute or ordinance.

**(k) Libel and slander.**

(k)(1) *Pleading defamatory matter.* In an action for libel or slander it is sufficient to allege generally that the defamatory matter out of which the action arose was published or spoken concerning the plaintiff. If the allegation is denied, the party alleging the defamatory matter must establish at trial that it was published or spoken.

(k)(2) *Pleading defense.* The defendant may allege the truth of the matter charged as defamatory and any mitigating circumstances to reduce the amount of damages. Whether or not justification is proved, the defendant may give evidence of the mitigating circumstances.

**(l) Allocation of fault.**

(l)(1) A party seeking to allocate fault to a non-party under Title 78B, Chapter 5, Part 8 must file:

(l)(1)(A) a description of the factual and legal basis on which fault can be allocated; and

  

(l)(1)(B) information known or reasonably available to the party identifying the nonparty, including name, address, telephone number and employer. If the identity of the non-party is unknown, the party must so state.

(l)(2) The information specified in paragraph (l)(1) must be included in the party's responsive pleading if then known or must be included in a supplemental notice filed within a reasonable time after the party discovers the factual and legal basis on which fault can be allocated. The court, upon motion and for good cause shown, may permit a party to file the information specified in paragraph (l)(1) after the expiration of any period permitted by this rule, but in no event later than 90 days before trial.

(l)(3) A party must not seek to allocate fault to another except by compliance with this rule.

**Credits**

[Amended effective November 1, 2003; May 2, 2005; November 1, 2008; November 1, 2011; November 1, 2016.]

**Editors' Notes**

**ADVISORY COMMITTEE NOTE**

The 2016 amendments deleted former paragraph (k) on renewing judgments because it was superfluous. The Renewal of Judgment Act (Utah Code Sections 78B-6-1801 through 78B-6-1804) allows a domestic judgment to be renewed by motion, and Section 78B-5-302 governs domesticating a foreign judgment, which can then be renewed by motion.

The process for renewing a judgment by motion is governed by Rule 58C.

Issues of capacity, conditions precedent, and statutes of limitation in paragraphs (a), (e), and (j) should be decided along with other claims and defenses.

Notes of Decisions (126)

Rules Civ. Proc., Rule 9, UT R RCP Rule 9
Current with amendments received through February 15, 2019

# Addendum I

895 F.3d 730
United States Court of Appeals, Tenth Circuit.

UNITED STATES of America EX REL. Gerald POLUKOFF, Plaintiff-Appellant,
v.
ST. MARK'S HOSPITAL; Intermountain Healthcare, Inc.; Sherman Sorensen, M.D.; Sorensen Cardiovascular Group; Intermountain Medical Center, Defendants-Appellees,
and
HCA, Inc., a/k/a HCA, Defendant.
United States of America,
Amicus Curiae and Intervenor.

No. 17-4014
|
FILED July 9, 2018

**Synopsis**

**Background:** Relator brought qui tam False Claims Act (FCA) action on behalf of the United States against cardiologist and two hospitals where he worked, alleging that cardiologist performed unnecessary heart surgeries and received reimbursement through Medicare by fraudulently certifying that the surgeries were medically necessary. The United States District Court for the District of Utah, Jill N. Parrish, J., 2017 WL 237615, granted cardiologist's and hospitals' motions to dismiss. Relator appealed.

**Holdings:** The Court of Appeals, Briscoe, Circuit Judge, held that:

relator stated FCA claim against cardiologist;

relator stated FCA claims against hospitals; and

relator's claim against hospital was pleaded with sufficient particularity.

Reversed and remanded.

***733 Appeal from the United States District Court for the District of Utah (D.C. No. 2:16-CV-00304-JNP-EJF)**

**Attorneys and Law Firms**

Tejinder Singh, Goldstein & Russell, P.C., Bethesda, Maryland (Thomas C. Goldstein, Goldstein & Russell, P.C., Bethesda, Maryland; Rand P. Nolen, George M. Fleming, Sylvia Davidow, Gregory D. Brown, David Hobbs, and Jessica A. Kasischke, Fleming, Nolen & Jez, LLP, Houston, Texas, with him on the briefs), appearing for Appellant.

J. Scott Ballenger, Latham & Watkins LLP, Washington DC (Alexandra P. Shechtel, Latham & Watkins LLP, Washington DC; Katherine A. Lauer, Latham & Watkins LLP, San Diego, California; Andrew A. Warth, W. David Bridgers, and Wells Trompeter, Waller Lansden Dortch & Davis LLP, Nashville, Tennessee, with him on the brief), appearing for Appellee St. Mark's Hospital.

Matthew L. Knowles, McDermott Will & Emery LLP, Boston, Massachusetts (M. Miller Baker, McDermott Will & Emery LLP, Washington, DC; Shamis Beckley and Alexander J. Kritikos, McDermott Will & Emery LLP, Boston, Massachusetts; Alan C. Bradshaw, Sammi V. Anderson, and Christopher M. Glauser, Manning Curtis Bradshaw & Bednar, PLLC, Salt Lake City, Utah; Daniel S. Reinberg and Asher D. Funk, Polsinelli PC, Chicago, Illinois, with him on the brief), appearing for Appellee Intermountain Healthcare, Inc. and Intermountain Medical Center.

Blaine J. Benard, Holland & Hart LLP, Salt Lake City, Utah, and Gregory Goldberg, Holland & Hart LLP, Denver, Colorado, on the brief for Appellees Sherman Sorensen M.D., and Sorensen Cardiology Group.

Sarah Carroll, Attorney, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC (Chad A. Readler, Acting Assistant Attorney General, United States Department of Justice, Washington, DC; John W. Huber, United States Attorney for the District of Utah, Salt Lake City, Utah; Douglas N. Letter and Michael S. Raab, Attorneys, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC), appearing for Intervenor and Amicus Curiae United States of America.

Before TYMKOVICH, Chief Judge, BRISCOE and HARTZ, Circuit Judges.

  

**Opinion**

BRISCOE, Circuit Judge.

***734** This is a *qui tam* action alleging violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729–33, involving fraudulent reimbursements under the Medicare Act, 42 U.S.C. §§ 1395–1395ccc. Plaintiff Gerald Polukoff, M.D., is a doctor who worked with Defendant Sherman Sorensen, M.D. After observing some of Dr. Sorensen's medical practices, Dr. Polukoff brought this FCA action, on behalf of the United States, against Dr. Sorensen and the two hospitals where Dr. Sorensen worked (collectively, "Defendants"). Dr. Polukoff alleges Dr. Sorensen performed thousands of unnecessary heart surgeries and received reimbursement through the Medicare Act by fraudulently certifying that the surgeries were medically necessary. Dr. Polukoff further alleges the hospitals where Dr. Sorensen worked were complicit in and profited from Dr. Sorensen's fraud. The district court granted Defendants' motions to dismiss, reasoning that a medical judgment cannot be false under the FCA. Exercising jurisdiction pursuant to 28 U.S.C. § 1291, we REVERSE and REMAND for further proceedings.

## I

### A. Statutory Background

"The FCA 'covers all fraudulent attempts to cause the government to pay out sums of money.' " *United States ex rel. Conner v. Salina Regional Health Ctr., Inc.*, 543 F.3d 1211, 1217 (10th Cir. 2008) (quoting *United States ex rel. Boothe v. Sun Healthcare Grp., Inc.*, 496 F.3d 1169, 1172 (10th Cir. 2007) ). Specifically, any person who:

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G); [or]
>
> ...
>
> (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
>
> is liable to the United States Government for a civil penalty [and treble damages].

31 U.S.C. § 3729(a)(1). The FCA defines the "knowingly" scienter requirement as follows:

> (A) mean[s] that a person, with respect to information—
>
> (i) has actual knowledge of the information;
>
> (ii) acts in deliberate ignorance of the truth or falsity of the information; or
>
> (iii) acts in reckless disregard of the truth or falsity of the information; and
>
> (B) require[s] no proof of specific intent to defraud ....

*Id.* § 3729(b)(1).

There are two options to remedy a violation of the FCA. "First, the Government itself may bring a civil action against the alleged false claimant." ***735** *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 769, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000). "Second, as is relevant here, a private person (the relator) may bring a *qui tam* civil action 'for the person and for the United States Government' against the alleged false claimant, 'in the name of the Government.' " *Id.* (quoting 31 U.S.C. § 3730(b)(1) ). If a relator files a *qui tam* civil action, the government may intervene and take over the case. 31 U.S.C. § 3730(b)(2). "If the government elects not to proceed with the action," the relator "shall have the right to conduct the action." *Id.* § 3730(c)(3). Depending on the specific circumstances of the *qui tam* suit, the government and the relator divide any proceeds derived from the suit. *Id.* § 3730(d).

The FCA is applicable to many statutes that provide for federal reimbursement of expenses. One such statute is the Medicare Act,[1] which imposes requirements for reimbursement of medical expenses. As relevant here, the Medicare Act states that "no payment may be made ... for any expenses incurred for items or services" that "are not *reasonable and necessary* for the diagnosis or treatment of illness or injury or to improve the functioning

of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A) (emphasis added). Physicians and medical providers who seek reimbursement under the Medicare Act must "certify the *necessity* of the services and, in some instances, recertify the continued need for those services." 42 C.F.R. 424.10(a) (Oct. 1, 2013) (emphasis added); *see also* 42 U.S.C. §§ 1395f(a), 1395n(a) (listing the various certifications).

[1] The amended complaint also references the "TRICARE/CHAMPUS Program." App'x at 521–22. This healthcare program benefits retired military personnel and dependents of both active and retired military personnel. *Id.* at 521; *see also Baptist Physician Hosp. Org., Inc. v. Humana Military Healthcare Servs., Inc.*, 368 F.3d 894, 895 (6th Cir. 2004). The amended complaint alleges that Defendants "submitted Requests for Reimbursement to TRICARE/CHAMPUS that were based on their submissions to Medicare." App'x at 522. We do not distinguish this program from Medicare and Medicaid in our analysis because Defendants failed to argue for any relevant distinction.

The Secretary of Health and Human Services decides "whether a particular medical service is 'reasonable and necessary' ... by promulgating a generally applicable rule *or* by allowing individual adjudication." *Heckler v. Ringer*, 466 U.S. 602, 617, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984) (emphasis added). The *former* course involves a "national coverage determination" that announces "whether or not a particular item or service is covered nationally." 42 U.S.C. § 1395ff(f)(1)(B). In the absence of a national coverage determination, local Medicare contractors may issue a "local coverage determination" that announces "whether or not a particular item or service is covered" by that contractor. *Id.* § 1395ff(f)(2)(B).

The *latter* course allows "contractors [to] make individual claim determinations, even in the absence of [a national or local coverage determination], ... based on the individual's particular factual situation." 68 Fed. Reg. 63,692, 63,693 (Nov. 7, 2003). In making an individual claim determination about whether to reimburse a medical provider, "[c]ontractors shall consider a service to be reasonable and necessary if the contractor determines that the service is: [ (1) ] Safe and effective; [ (2) ] Not experimental or investigational ...; and [ (3) ] Appropriate." Centers for Medicare & Medicaid Services ("CMS"),[2] *Medicare* ***736** *Program Integrity Manual* § 13.5.1 (2015) (describing local coverage determinations); *see also id.* § 13.3 (incorporating § 13.5.1's standards for individual claim determinations). One factor that contractors consider when deciding whether a service is "appropriate" is whether it is "[f]urnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member." *Id.* § 13.5.1.

[2] CMS is an agency within Health and Human Services, *see Protocols, LLC v. Leavitt*, 549 F.3d 1294, 1295 (10th Cir. 2008), and this agency administers the Medicare Act, *see United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702, 705 & n.1 (10th Cir. 2006).

**B. Factual Background**

"At the motion-to-dismiss stage, we must accept all the well-pleaded allegations of the complaint as true and must construe them in the light most favorable to the plaintiff." *Albers v. Bd. of Cty. Comm'rs of Jefferson Cty.*, 771 F.3d 697, 700 (10th Cir. 2014) (quotation omitted). As a result, we rely on Dr. Polukoff's amended complaint.[3]

[3] Although Dr. Polukoff filed a motion (and later, an amended motion) for leave to file a second amended complaint, the district court denied the amended motion. Thus, Dr. Polukoff's amended complaint is the operative complaint.

***1. The PFO closure procedure***

This case involves two very similar cardiac conditions: patent foramen ovale ("PFO") and atrial septal defect ("ASD"). Both PFOs and ASDs involve a hole between the upper two chambers of the heart, but they have different causes. Most people are born with a PFO, as it helps blood circulate throughout the heart while in the womb, but for 75% of the population, the hole closes soon after birth. ASDs, on the other hand, are an abnormality. Regardless, both PFOs and ASDs allow blood to flow in the wrong direction within the upper chambers of the heart. In rare cases, they can lead to a variety of dangerous complications, including stroke. Physicians can "close" ASDs and PFOs through ASD and PFO closures (collectively, "PFO closures"), a percutaneous surgical procedure involving cardiac catheterization. In layman's terms, physicians insert a thin tube into a blood vessel

to access the heart, rather than performing open heart surgery.

The amended complaint makes specific reference to industry guidelines published by the American Heart Association and American Stroke Association (the "AHA/ASA Guidelines") in 2006 and 2011, related to PFO closures. [4] The 2006 AHA/ASA Guidelines observed that "[s]tudies have found an association between PFO and cryptogenic stroke." [5] App'x at 2077. They noted "conflicting reports concerning the safety and efficacy of surgical PFO closure" to treat cryptogenic stroke, but after reviewing several studies, also noted that each reported "no major complications." *Id.* The 2006 AHA/ASA Guidelines concluded: "Insufficient data exist to make a recommendation about PFO closures in patients with a first stroke and a PFO. PFO closure may be considered for patients with recurrent cryptogenic stroke despite optimal medical therapy ...." *Id.* at 2079. In other words, the 2006 AHA/ASA Guidelines advised that (1) for patients with two or more cryptogenic strokes, PFO closures may be considered; (2) for patients with only one cryptogenic stroke, there was insufficient data to make a recommendation; and (3) for patients without a single cryptogenic stroke, the ***737** AHA/ASA Guidelines did not contemplate the potential for PFO closures.

4 The amended complaint also references the 2014 AHA/ASA Guidelines. Those guidelines, however, were published after all relevant conduct occurred in this case, and thus are irrelevant.

5 A "cryptogenic stroke" describes a stroke for which the cause is unknown.

The 2011 AHA/ASA Guidelines are similarly inconclusive. In a table titled "Recommendations for Stroke Patients With Other Specific Conditions," the guidelines stated: "There are insufficient data to make a recommendation regarding PFO closure in patients with stroke and PFO ...." *Id.* at 2125. The 2011 AHA/ASA Guidelines did, however, observe that recent "studies provide[d] new information on options for closure of PFO and generally indicate[d] that short-term complications with these procedures are rare and for the most part minor." *Id.* at 2126.

Relying on the AHA/ASA Guidelines, the amended complaint alleges "[t]here has long been general agreement in the medical community that PFO closure is not medically necessary, except in the limited circumstances where there is a confirmed diagnosis of a recurrent cryptogenic stroke or TIA, [6] despite optimum medical management." *Id.* at 524.

6 A "TIA" is a "transient ischemic attack," which is a brief interruption of blood flow to the brain that causes stroke-like symptoms.

***2. The Defendants' conduct***

Dr. Sorensen practiced medicine as a cardiologist in Salt Lake City, Utah. He was the principal shareholder of Sorensen Cardiovascular Group ("SCG"). Dr. Sorensen, through SCG, provided cardiology services at two hospitals: (1) Intermountain Medical Center and (2) St. Mark's Hospital ("St. Mark's"). Intermountain Medical Center is part of a large network of hospitals in Utah principally owned by Intermountain Healthcare, Inc., a not-for-profit corporation (collectively, with Intermountain Medical Center, "Intermountain"). St. Mark's, on the other hand, is a for-profit corporation owned by HCA, Inc. Dr. Polukoff is a practicing cardiologist who worked with Dr. Sorensen at both St. Mark's and Intermountain.

Dr. Sorensen started providing cardiology services at Intermountain in December 2002. Later, in 2008, he began working at St. Mark's as well. Part of his practice included performing a relatively high number of PFO closures. For example, "[t]he Cleveland Clinic reported that it had performed 37 PFO closures in 2010; during that same time period [Dr.] Sorensen's billing records indicate that he had performed 861." *Id.* at 542. The amended complaint alleges that Dr. Sorensen performed so many PFO closures because of "his medically unsupported belief that PFO closures would cure migraine headaches or prevent strokes." *Id.* In addition, "Dr. Sorensen knew that Medicare and Medicaid would not pay for PFO closures to treat migraines, so he chose to represent that the procedures had been performed based upon indications set forth in the AH[A]/ASA stroke guidelines—the existence of confirmed recurrent cryptogenic stroke." *Id.*

The amended complaint describes Dr. Sorensen's medical notes and reasons for the large number of PFO closures:

> Dr. Sorensen's notes in his patients' medical records indicate that [Dr.] Sorensen fully understands, but rejects, the standard of care for PFO/ASD closures

> set forth in the [AHA/ASA] Guidelines described above. For example, Dr. Sorensen notes that closures are considered medically necessary only for recurrent cryptogenic strokes or TIA, secondary to paradoxical embolization despite medical therapy, but argues that while "[w]e do have experience with the two strokes first and then closure approach, we ***738** found this very unsatisfactory as a very high number of patients were disabled and disability is not reversed by closure." Dr. Sorensen notes that "[w]e therefore follow a preventative strategy and risk stratify the patient. ..." Dr. Sorensen notes that he considers waiting for a stroke or TIA to reoccur before proceeding to closure is "unethical."

*Id.* at 607.

In early 2011, several doctors at Intermountain objected to Dr. Sorensen's approach to PFO closures, claiming Dr. Sorensen was violating Intermountain's internal guidelines for PFO closures. In March 2011, in response to the objections, Intermountain adopted new internal guidelines for PFO closures that mirrored the AHA/ASA Guidelines. In May 2011, Intermountain conducted an investigation into Dr. Sorensen's practice and internally released an audit of the 47 PFO closures Dr. Sorensen performed in April 2011. The audit concluded that "the guidelines had been violated in many of the 47 cases reviewed." *Id.* at 535.

On June 27, 2011, following the internal investigation, Intermountain suspended Dr. Sorensen's cardiac privileges. The suspension was effective until July 11, 2011. On July 12, 2011, Dr. Sorensen returned to Intermountain, but continued to violate the hospital's internal guidelines for PFO closures. Intermountain discovered the continued violations, and subsequently entered into a settlement agreement with Dr. Sorensen to avoid his permanent suspension. Intermountain later found that Dr. Sorensen had violated the terms of the settlement agreement and moved to permanently suspend Dr. Sorensen, but Dr. Sorensen tendered his resignation in September 2011.

After Dr. Sorensen left Intermountain, he moved his entire practice to St. Mark's. St. Mark's knew of Dr. Sorensen's suspension from Intermountain, but courted his moving his practice anyway. St. Mark's allowed Dr. Sorensen to continue his cardiology practice until he retired from medical practice altogether a few months later, on December 9, 2011.

Dr. Polukoff—the relator in this case—worked at both Intermountain and St. Mark's, but not directly for Dr. Sorensen until 2011. On June 11, 2011, Dr. Polukoff signed an employment agreement with SCG to learn PFO closures from Dr. Sorensen, and on August 17, 2011, actually began working for Dr. Sorensen at St. Mark's. While working for Dr. Sorensen, Dr. Polukoff "personally observed [Dr.] Sorensen perform medically unnecessary PFO closures on patients at St. Mark's." *Id.* at 536. He alleges to have "observed [Dr.] Sorensen *create* a PFO by puncture of the atrial septum in patients who were found to have an intact septum during surgery." *Id.*

The amended complaint further alleges that St. Mark's and Intermountain "signed or caused to be executed provider agreements with Medicare that permitted each Defendant to submit claims and accept payment for services." *Id.* at 518. Both hospitals "allowed and encouraged Dr. Sorensen to perform and submit claims to federal health benefit programs for PFO and ASD procedures despite clear compliance red flags, including, but not limited to, the fact that Dr. Sorensen was performing these procedures at a rate that far exceeded that of any other institution or physician." *Id.* at 507.

**C. Procedural Background**

On December 6, 2012, Dr. Polukoff filed this *qui tam* action under seal in the United States District Court for the Middle District of Tennessee against: (1) Dr. Sorensen; (2) Sorensen Cardiovascular Group; (3) Intermountain Healthcare, Inc.; (4) St. ***739** Mark's Hospital; and (5) HCA, Inc. On June 15, 2015, the government filed its notice of election to decline intervention. On June 19, 2015, the district court unsealed the *qui tam* complaint. All Defendants moved to dismiss the action.

Dr. Polukoff then filed an amended complaint against all Defendants previously named, and added Intermountain Medical Center. The amended complaint alleged four separate violations of the FCA, corresponding to four separate subsections of the FCA. *Id.* at 611–14 (citing 31 U.S.C. § 3729(a)(1)(A)–(C), (G) ). All Defendants moved to dismiss the amended complaint. The district court dismissed the claims against HCA, and concluded that, without HCA, venue in the United States District Court for the Middle District of Tennessee was no longer

proper. Consequently, the district court transferred the case to the United States District Court for the District of Utah, without ruling on the motions to dismiss as to the remaining Defendants—Dr. Sorensen (both as an individual and the Sorensen Cardiovascular Group); Intermountain (both the individual hospital and the nonprofit that owned it); and St. Mark's.

The remaining Defendants filed renewed motions to dismiss. Oral arguments were scheduled for November 10, 2016. The day before oral arguments, Dr. Polukoff filed a motion for leave to file an amended complaint. The district court heard oral arguments as scheduled. Before the district court ruled on the motions to dismiss, Dr. Polukoff filed an amended motion for leave to file a second amended complaint on January 18, 2017. The next day, the district court granted Defendants' motions to dismiss, with prejudice, and denied Dr. Polukoff's motion for leave to amend.

As relevant to this appeal, the district court first addressed Defendants' Rule 9(b) argument that Dr. Polukoff had failed to plead with particularity. The district court determined that the proper standard was "whether Dr. Polukoff has pled the who, what, when, where and how of a fraudulent scheme perpetrated by each of the defendants." *Id.* at 2519. "In addition, the court must decide whether the operative complaint provides 'an adequate basis for a reasonable inference that false claims were submitted as part of that scheme.' " *Id.* (quoting *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir. 2010) ). The court concluded that Dr. Polukoff had adequately pled his claims against Dr. Sorensen and St. Mark's but not against Intermountain because he failed to identify a "managing agent" involved in the conspiracy at Intermountain. *Id.* at 2519–22.

The court then turned to Defendants' Rule 12(b)(6) argument. Relying on language from this court's unpublished decision in *United States ex rel. Morton v. A Plus Benefits, Inc.*, 139 F. App'x 980 (10th Cir. 2005), the district court concluded that "Dr. Polukoff must show that the defendants knowingly made an objectively false representation to the government that caused the government to remit payment." App'x at 2526. It observed that "Dr. Polukoff's FCA causes of action rest upon his contention that the defendants represented (either explicitly or implicitly) that the PFO closures performed by Dr. Sorensen were medically reasonable and necessary and that this representation was false." *Id.* at 2524. But, because "[o]pinions, medical judgments, and 'conclusions about which reasonable minds may differ cannot be false' for the purposes of an FCA claim," *id.* at 2526 (quoting *Morton*, 139 F. App'x at 983), Dr. Sorensen's representations to the government could not be false absent "a regulation that clarifies the conditions under which it will or will not pay for a PFO closure," *id.* at 2528. Thus, Dr. Polukoff's ***740** "FCA claims fail[ed] as a matter of law and the court dismisse[d] all causes of action asserted against the defendants." *Id.* at 2529. The court further determined that "leave to amend would be futile," *id.*, so it dismissed the amended complaint with prejudice.

Dr. Polukoff timely appealed. The government filed an amicus brief in his support. All three Defendants—Dr. Sorensen, St. Mark's, and Intermountain—filed response briefs. Of particular note, in Intermountain's brief, it argued that the *qui tam* provisions of the FCA violate Article II of the U.S. Constitution. The government intervened thereafter, pursuant to 28 U.S.C. § 2403(a), to respond to Intermountain's constitutional argument in an additional brief as intervenor.

## II

The district court relied upon Rules 12(b)(6) and 9(b) to dismiss Dr. Polukoff's amended complaint with prejudice. We address the district court's holdings in turn. [7]

[7] Intermountain argues, for the first time on appeal, that "at least where the Government has not intervened, a private relator's prosecution of an FCA case on behalf of the Government violates the separation of powers." Intermountain Br. at 54. Intermountain concedes it "did not assert a constitutional challenge below." *Id.* at 54 n.11. We consider this argument forfeited. "It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below." *Singleton v. Wulff*, 428 U.S. 106, 120, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976). "[W]here the ground presented here has not been raised below we exercise this authority [to consider the newly raised argument] 'only in exceptional cases.' " *Heckler v. Campbell*, 461 U.S. 458, 468 n.12, 103 S.Ct. 1952, 76 L.Ed.2d 66 (1983) (quoting *McGoldrick v. Compagnie Generale*

> *Transatlantique*, 309 U.S. 430, 434, 60 S.Ct. 670, 84 L.Ed. 849 (1940) ). "[T]he decision regarding what issues are appropriate to entertain on appeal in instances of lack of preservation is discretionary." *Abernathy v. Wandes*, 713 F.3d 538, 552 (10th Cir. 2013). We decline to address Intermountain's separation of powers argument.

**A. Rule 12(b)(6)**

We first address the district court's conclusion that, absent a specific regulation addressing the necessity of the treatment, a physician's medical judgment concerning the necessity of a treatment could not be "false or fraudulent" under the FCA. As a result of this conclusion, the district court dismissed Dr. Polukoff's amended complaint under Rule 12(b)(6), believing it failed to state a claim as a matter of law, and then denied leave to amend, believing amendment would have been futile. We disagree.

"We review the district court's dismissal under Rule 12(b)(6) de novo." *Lemmon*, 614 F.3d at 1167. "Although we generally review for abuse of discretion a district court's denial of leave to amend a complaint, when this 'denial is based on a determination that amendment would be futile, our review for abuse of discretion includes de novo review of the legal basis for the finding of futility.' " *Cohen v. Longshore*, 621 F.3d 1311, 1314 (10th Cir. 2010) (quoting *Miller ex. Rel. S.M. v. Bd. of Educ. of Albuquerque Pub. Schs.*, 565 F.3d 1232, 1250 (10th Cir. 2009) ).

"Enacted in 1863, the False Claims Act 'was originally aimed principally at stopping the massive frauds perpetrated by large contractors during the Civil War.' " *Universal Health Servs., Inc. v. United States ex rel. Escobar*, —— U.S. ——, 136 S.Ct. 1989, 1996, 195 L.Ed.2d 348 (2016) (quoting *United States v. Bornstein*, 423 U.S. 303, 309, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976) ). " '[A] series of sensational congressional investigations' prompted hearings where witnesses 'painted a sordid picture ***741** of how the United States had been billed for nonexistent or worthless goods, charged exorbitant prices for goods delivered, and generally robbed in purchasing the necessities of war.' " *Id.* (quoting *United States v. McNinch*, 356 U.S. 595, 599, 78 S.Ct. 950, 2 L.Ed.2d 1001 (1958) ).

Today, the FCA generally prohibits private parties from "knowingly" submitting "a false or fraudulent claim" for reimbursement. 31 U.S.C. § 3729(a)(1)(A). Unfortunately, "Congress did not define what makes a claim 'false' or 'fraudulent.' " *Escobar*, 136 S.Ct. at 1999. Without a definition from Congress, the Supreme Court has turned to common law. And "common-law fraud has long encompassed ... more than just claims containing express falsehoods." *Id.* Consequently, the Court favors a more expansive view of "false or fraudulent."

As we have held, "false or fraudulent" includes both factually false and legally false requests for payment. *See Lemmon*, 614 F.3d at 1168. "Factually false claims generally require a showing that the payee has submitted an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided." *United States ex rel. Thomas v. Black & Veatch Special Projects Corp.*, 820 F.3d 1162, 1168 (10th Cir. 2016) (quotation omitted). "Claims arising from legally false requests, on the other hand, generally require knowingly false certification of compliance with a regulation or contractual provision as a condition of payment." *Id.* In this case, Dr. Polukoff does not allege Dr. Sorensen submitted *factually* false requests because his claims do not focus on an inaccuracy of the PFO closures performed. Instead, he claims the PFO closures do not comply with Medicare's "reasonable and necessary" requirement, meaning Dr. Sorensen submitted *legally* false requests for payment.

"Such claims of legal falsity can rest on one of two theories—express false certification, and implied false certification." *Id.* at 1169 (quotation and brackets omitted). "An express false certification theory applies when a government payee falsely certifies compliance with a particular statute, regulation or contractual term, where compliance is a prerequisite to payment." *Conner*, 543 F.3d at 1217 (quotation omitted). "By contrast, the pertinent inquiry for implied-false-certification claims is not whether a payee made an affirmative or express false statement, but whether, through the act of submitting a claim, a payee knowingly and falsely implied that it was entitled to payment." *Thomas*, 820 F.3d at 1169 (quotation and brackets omitted).

As relevant here, Dr. Polukoff brings express-false-certification claims against Dr. Sorensen. The amended complaint alleges Dr. Sorensen submitted express false certifications when he signed and submitted CMS Form 1500, which states: "I certify that the services shown on this form were medically indicated and necessary for the health of the patient. ..." App'x at 518.

The district court concluded that Dr. Polukoff's express-false-certification claims were not legally cognizable under the FCA. First, it held that "medical judgments and 'conclusions about which reasonable minds may differ cannot be false' for the purposes of an FCA claim." App'x at 2526 (quoting *Morton*, 139 F. App'x at 983). Second, the district court determined that a physician's certification that a PFO closure was "reasonable and necessary" could not be false under the FCA—given that it would constitute a medical judgment—absent "a regulation that clarifies the conditions under which [the government ***742** ] will or will not pay for a PFO closure." *Id.* at 2528.

*Morton* is narrower than the district court suggests. First, *Morton* involved the application of the FCA to ERISA, not Medicare. Second, we explicitly cabined *Morton* to the facts in that case:

> We agree that liability under the FCA must be predicated on an objectively verifiable fact. Nonetheless, we are not prepared to conclude that in all instances, merely because the verification of a fact relies upon clinical medical judgments, or involves a decision of coverage under an ERISA plan, the fact cannot form the basis of an FCA claim. In this case, the nature of neither the scientific nor contract determinations inherent in the formation and evaluation of the allegedly "false" statement is susceptible to proof of truth or falsity.

139 F. App'x at 983. We did not create a bright-line rule that a medical judgment can never serve as the basis for an FCA claim.

It is possible for a medical judgment to be "false or fraudulent" as proscribed by the FCA for at least three reasons. First, we read the FCA broadly. *See United States v. Neifert-White Co.*, 390 U.S. 228, 232, 88 S.Ct. 959, 19 L.Ed.2d 1061 (1968) (observing that the FCA "was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government," and "refus[ing] to accept a rigid, restrictive reading"). Second, "the fact that an allegedly false statement constitutes the speaker's opinion does not disqualify it from forming the basis of FCA liability." *United States ex rel. Loughren v. Unum Grp.*, 613 F.3d 300, 310 (1st Cir. 2010) (holding, in the Social Security benefits context, that "an applicant's opinion regarding the date on which he became unable to work" can give rise to FCA liability); *cf. Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, —— U.S. ——, 135 S.Ct. 1318, 1326, 191 L.Ed.2d 253 (2015) (suggesting, in the securities context, that a "false-statement provision ... appl[ies] to expressions of opinion"). Third, "claims for medically unnecessary treatment are actionable under the FCA." *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) (holding relator's complaint "sufficiently allege[d] that statements were known to be false, rather than just erroneous, because she assert[ed] that Defendants ordered the services knowing they were unnecessary"); *cf. Frazier ex rel. United States v. Iasis Healthcare Corp.*, 392 F. App'x 535, 537 (9th Cir. 2010) (affirming FCA claim was inadequately pled, but suggesting an FCA claim could survive if the relator "provide[s] 'reliable indicia' that [the defendant] submitted claims for medically unnecessary procedures").

As the government states in its amicus brief, "A Medicare claim is false if it is not reimbursable, and a Medicare claim is not reimbursable if the services provided were not medically necessary." Amicus Br. at 14. For a claim to be reimbursable, it must meet the government's definition of "reasonable and necessary," as found in the Medicare Program Integrity Manual. The manual instructs contractors to "consider a service to be reasonable and necessary" if the procedure is:

- Safe and effective;
- Not experimental or investigational ...; and
- Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:
  - # Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the ***743** patient's condition or to improve the function of a malformed body member;

# Furnished in a setting appropriate to the patient's medical needs and condition;

# Ordered and furnished by qualified personnel;

# One that meets, but does not exceed, the patient's medical need; and

# At least as beneficial as an existing and available medically appropriate alternative.

CMS, *Medicare Program Integrity Manual* § 13.5.1; *see also id.* § 13.3 (incorporating § 13.5.1's definition of reasonable and necessary for individual claim determinations).

We thus hold that a doctor's certification to the government that a procedure is "reasonable and necessary" is "false" under the FCA if the procedure was not reasonable and necessary under the government's definition of the phrase. We understand the concerns that a broad definition of "false or fraudulent" might expose doctors to more liability under the FCA, but the Supreme Court has already addressed those concerns: "Instead of adopting a circumscribed view of what it means for a claim to be false or fraudulent, concerns about fair notice and open-ended liability can be effectively addressed through strict enforcement of the [FCA]'s materiality and scienter requirements. Those requirements are rigorous." *Escobar*, 136 S.Ct. at 2002 (quotation marks and some brackets omitted).

In this case, Dr. Polukoff adequately alleges that Dr. Sorensen performed unnecessary PFO closures on patients and then knowingly submitted false certifications to the federal government that the procedures were necessary, all in an effort to obtain federal reimbursement. Specifically, Dr. Polukoff alleges: (1) Dr. Sorensen performed an unusually large number of PFO closures, App'x at 542 ("The Cleveland Clinic reported that it had performed 37 PFO closures in 2010; during that same time period [Dr.] Sorensen's billing records indicate that he had performed 861."); (2) these procedures violated both industry guidelines and hospital guidelines, *id.* at 524–26, 535; (3) other physicians objected to Dr. Sorensen's practice, *id.* at 535; (4) Intermountain eventually audited Dr. Sorensen's practice, and concluded that its "guidelines had been violated in many of the 47 cases reviewed," *id.*; and (5) "Dr. Sorensen knew that Medicare and Medicaid would not pay for PFO closures to treat migraines, so he chose to represent that the procedures had been performed based upon indications set forth in the AH[A]/ASA stroke guidelines—the existence of confirmed recurrent cryptogenic stroke," *id.* at 542. Under these specific factual allegations, Dr. Polukoff has pleaded enough to state a claim as a matter of law and survive Rule 12(b)(6) dismissal against Dr. Sorensen.

We further hold the amended complaint adequately states express-false-certification claims against St. Mark's and Intermountain, both of which allegedly "billed for the hospital charges associated with" PFO closures. *Id.* at 542–43. More specifically, the amended complaint alleges St. Mark's and Intermountain both requested reimbursements for these procedures by submitting annual Hospital Cost Reports. The reports require hospitals to certify: "I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations." *Id.* at 516. By submitting a Hospital Cost Report, then, St. Mark's and Intermountain ***744** expressly certified that every procedure for which they sought reimbursement complied with Medicare's requirements. Because the complaint adequately alleges that Dr. Sorensen's surgeries and any procedure associated therewith was not, in fact, "reasonable and necessary," the complaint adequately alleges that St. Mark's and Intermountain submitted false claims for reimbursement to the government through their Hospital Cost Reports.

Moreover, Dr. Polukoff adequately alleges St. Mark's and Intermountain submitted these false certifications "knowingly." As to St. Mark's, Dr. Polukoff alleges that he personally told the CEO about the circumstances surrounding Dr. Sorensen's suspension from Intermountain for performing unnecessary PFO closures. Nonetheless, according to Dr. Polukoff, St. Mark's continued to recruit Dr. Sorensen's business:

> Contemporaneously with his suspension from Intermountain, St. Mark's executive management knew that [Dr.] Sorensen had been suspended for performing medically unnecessary PFO closures. Dr. Polukoff personally discussed the

> suspension with the CEO of St. Mark's Hospital, Steve Bateman, and his physician liaison, Nikki Gledhill. Despite the fact that St. Mark's knew that [Dr.] Sorensen was performing medically unnecessary PFO closures, and knew that [Dr.] Sorensen had been suspended from Intermountain for performing medically unnecessary PFO closures, St. Mark's Hospital continued to court [Dr.] Sorensen's septal closure business and provide a platform and assistance to [Dr.] Sorensen.

*Id.* at 540–41.

As to Intermountain, Dr. Polukoff alleges that, "at all times relevant to this case, Intermountain knew that septal closures were rarely indicated." *Id.* at 535. This is because, "[f]or years Intermountain ignored the loud objections from its own medical staff and leadership, including the Director of the Catheterization Laboratory, Dr. Revenaugh, and the Medical Director for Cardiovascular Services at Intermountain Healthcare, Dr. Lappe, as well as written warnings and complaints from Professor Andrew Michaels of the University of Utah." *Id.* Because Dr. Sorensen performed an excessively large number of profitable PFO closures for Intermountain, Dr. "Sorensen was given his own catheterization lab room at Intermountain and provided with a handpicked staff of Intermountain employees." *Id.* at 610. "No other cardiologist received this type of special treatment from Intermountain." *Id.*

The FCA requires a defendant submit a false claim "knowingly," which includes the submission of claims by an entity who "acts in deliberate ignorance of the truth or falsity of the information" or "acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A). At a minimum, the amended complaint adequately alleges that St. Mark's and Intermountain acted with reckless disregard as to whether the PFO closures Dr. Sorensen was performing were medically necessary.

**B. Rule 9(b)**

All Defendants also challenged the amended complaint under Rule 9(b), arguing that Dr. Polukoff had failed to plead his claims with sufficient particularity. The district court denied the motions as to Dr. Sorensen and St. Mark's, but granted the motion as to Intermountain. Dr. Polukoff appeals, arguing his amended complaint pleaded allegations against Intermountain with sufficient particularity to survive a ***745** motion to dismiss under Rule 9(b). We agree with Dr. Polukoff.

Rule 9(b) states: "In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally." Fed. R. Civ. P. 9(b). "Concerning the failure to plead fraud with particularity under Rule 9(b), we ... review a dismissal de novo." *Lemmon*, 614 F.3d at 1167.

The purpose of Rule 9(b) is "to afford defendant[s] fair notice of plaintiff's claims and the factual ground upon which [they] are based." *Id.* at 1172 (quotations omitted). "Thus, claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme." *Id.* Practically speaking, FCA claims comply with Rule 9(b) when they "provid[e] factual allegations regarding the who, what, when, where and how of the alleged claims." *Id.* But, "in determining whether a plaintiff has satisfied Rule 9(b), courts may consider whether any pleading deficiencies resulted from the plaintiff's inability to obtain information in the defendant's exclusive control." *George v. Urban Settlement Servs.*, 833 F.3d 1242, 1255 (10th Cir. 2016). This reflects the principle that "Rule 9(b) does not require omniscience; rather the Rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim." *Williams v. Duke Energy Int'l, Inc.*, 681 F.3d 788, 803 (6th Cir. 2012) (quotation omitted).

The district court dismissed Dr. Polukoff's allegations against Intermountain under Rule 9(b) because "vital information regarding who knew what and when they knew it [was] missing." App'x at 2521–22. But, for many of the same reasons the amended complaint survived Rule 12(b)(6) against all Defendants, it survives Rule 9(b) as well. Rule 9(b) itself states: "Malice, intent, *knowledge*, and other conditions of a person's mind may be alleged *generally*." Fed. R. Civ. P. 9(b) (emphases

added). Moreover, we excuse deficiencies that result from the plaintiff's inability to obtain information within the defendant's exclusive control. *See George*, 833 F.3d at 1255. Intermountain,[8] no doubt, knows which employees handle federal billing for procedures reimbursable under Medicare, and in particular, who reviewed reimbursement claims for Dr. Sorensen during his decade there.[9]

8 This applies with equal force to St. Mark's. But, because the district court determined that Dr. Polukoff satisfied Rule 9(b)'s particularity requirements as to St. Mark's, we limit our discussion of Rule 9(b) to Intermountain.

9 In discussing the legal background of Rule 9(b), the district court stated: "Because both [Intermountain] and St. Mark's are corporations, this knowledge must be held by a managing agent of either of these corporate entities." App'x at 2521. The district court then failed to cite any authority for its "managing agent" theory. To the extent the district court relied upon the "managing agent" theory, we disagree. "It is well established that a corporation is chargeable with the knowledge of its agents and employees acting within the scope of their authority." *W. Diversified Servs., Inc. v. Hyundai Motor Am., Inc.*, 427 F.3d 1269, 1276 (10th Cir. 2005); *see also United States ex rel. Jones v. Brigham & Women's Hosp.*, 678 F.3d 72, 82 n.18 (1st Cir. 2012) ("We have long held that corporate defendants may be subject to FCA liability when the alleged misrepresentations are made while the employee is acting within the scope of his or her employment."). Thus, under Rule 9(b), it suffices that *any* employee, acting within the scope of his or her employment, had knowledge.

## III

Because Dr. Polukoff's amended complaint satisfies the pleading requirements ***746** of Rules 12(b)(6) and 9(b), we REVERSE and REMAND this case for further proceedings.

### All Citations

895 F.3d 730, Med & Med GD (CCH) P 306,327

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